Registrar

JAN 0 6 2005

Richard Williams

ORIGINAL

	an		ist)					2. Date of De Month	Day Y	3. Time of Deat
/Medi	al		on Woodrin	ıg	45 675 7		-1115		RY 14,20	
Examir	er	4a. Facility Name (If not institution, girl WASHINGTON COUNTY			HAGE	rown, or Loc RSTOW	1		4c. County of WASHING	
Funeral Director			Sex 7. Agu 1. Som 2. F	e (In yrs. last bin	thday) If Under 1 Yrs. Months		Under 24 Hr ours Min		th (1969)	9. Birthplace (State or Fore Country) PA
wow		Usual Residence of Decedent 10a. State 10b. County	.	10c. City, Town						10d. Inside City Lin
or 28e-f show	Director	MD Washing	gton 	наде	erstown 10f. Zip (Code			10g. Citizen of Wh	1 Tes 2 3
23a or	al Dir	18223 Maugans	s Ave.		Tot. Zip v	2174	40		USA	iat Gounty!
i, or items	oy Fune	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		13. Was Decede If Yes, speci		nic Origin? (lexican, Pue pecify:	Specify Yes or No rto Rican, etc.)	14. Race Black, Specify:	- American Indian, , White, etc. White
Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show iny follury or other treumatic event, the Madical Examinar must be notified at ance.	Completed by Funeral	15. Decedent's E (Specify only highest gi	ducation		Decedent's Usual (Give kind of work life. DO NOT use	l Occupation k done durin e retired)	g most of w	orking	16b. Kind of Busi	-
al Hygien d other th event, the	Be	17. Father's Name (First, Middle, Las	0	,	Loader	18.			, Maiden Sumame,	ution center
nd Ment marker matic	2	Stephen L. Woo		19b	. Mailing Address	(Street and)		ny A. Man	er, City or Town, Si	Itate Zio Code)
ealth ar n 27 is ser treu		Stephen L. Wood		ther P	2. 0. Box	421,		esboro, E	PA 17268	
ent of H nt: If iter ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special Control of the Contr		- 1	f Disposition (Nam ry, crematory or oth Hill Cen		Tan	2005	20c. Location - C Waynesbo	oro, PA
Departm importer any in¦ur once.		21. Signature of Funeral Service Lice			22. Name and	d Address of	Facility G1	cove-Bowe	-	eral Home,
ysician Medical caminer		Immediate Cause (Final disease or condition resulting in death)	a Heroin Due to (or as	A consequence						
hysician and the burial-transit	ilcal Examiner	Sequentially list conditions, and the sequentially list conditions, and the sequential s	с.	a consequence						
as as	cal	that initiated events	c. Due to (or as d. 23c. If yes, outcome	a consequence	of):				23d. Date Monti	of delivery h Day Year
by the attending particular parties for use as f	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. Due to (or as d	a consequence of pregnancy 2 Fetal death	of): 3 Sectopic pre 5 Other (spe	ecify)	Part I.		Monti obacco use contrib	th Day Year
by the attending particular parties for use as f	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	c. Due to (or as d	a consequence of pregnancy 2 Fetal death	of): 3 Sectopic pre 5 Other (spe	use given in		1 24a. Was auto perfe	obacco use contrib Yes 2 \Boxed No 3 an 24b. We proposy de 2 \Boxed No 1 \Boxe	th Day Year Dute to the cause of death B Probably 4 Dunknown
by the attending particular parties for use as f	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. Due to (or as d	a consequence of pregnancy 2 Fetal death time of death	of): 3 Ectopic pre 5 Other (spe	use given in	. Place of De	24a. Was auto perfe	obacco use contrib Yes 2 \Boxed No 3 an 24b. We proposy de 2 \Boxed No 1 \Boxe	oute to the cause of death Probably 4 Unknown Probably 4 Unknown Probably 5 Unknown Probably 6 Unknown Probably 7 Unknown Probably 7 Unknown Probably 8 Unknown Probably 9 Un
Iter this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b Hospital: 1 Inpatie 28a. Date of Inju (Month. Da) Found	of pregnancy 2 Fetal death time of death ut not resulting in	of): 3 Sectopic pre 5 Other (spe n the underlying ca	use given in	. Place of De	24a. Was auto perfet 1 Personal Mark (Check only of Home 5 Residue)	obacco use contrib Yes 2 \(\text{No} \) 3 an 24b. We promed? de 2 \(\text{No} \) No 1 \(\text{Cone} \)	oute to the cause of death' Probably 4 Unknown Probably 5 Unknown Probably 6 Unknown Probably 7 Unknown Probably 8 Unknown Probably 9 U
Iter this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? VA Yes 2 No 27. Manner of Death 1 Natural 5 Pending	C. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	of pregnancy 2 Fetal death time of death ut not resulting in ant XXER/Ou any y Year) Year 28b. Fou 27y 41y 41y 41y 41y 41y 41y 41y 41y 41y 41	of): 3 Sectopic pre 5 Other (spe n the underlying ca	26. A Other: Work?	. Place of De	24a. Was auto perfect yes aath (Check only of the control of the c	Monti obacco use contrib Yes 2 No 3 an 24b. We promed? 22 No 15 one) dence 6 Other how injury occurred	oute to the cause of death' B Probably 4 Junknotere autopsy findings availator to completion of cause autopsy findings availator? Wes 2 No
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Iter this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b 28a. Date of Inju Found 1 28a. Date of Inju Found 5 28. Place of Inju Found 1 hysician: To the bass of and manner str	of pregnancy 2 Fetal death time of death ut not resulting in y Year) Four ury - At home, fac. (Specify) n home of my knowledge of examination an	of): 3 Ectopic pre 5 Other (spe n the underlying ca utpatient 3 DO/ Time of n M arm, street, factory, e, death occurred a nd/or investigation,	26. A Other: A Work? 1 Yes, office	Place of De Nursing 2 No late and place on, death occumber	24a. Was auto perfect of the perfect	Monti Obacco use contrib Yes 2 No 3 an 24b. We proposed? de 2 No 15 One) dence 6 Other how injury occurred Street and Number wm, State) 1822 Cown, MD cause(s) and manual date and place, an 29d. Date signed (JANIJARY 1	oute to the cause of death's probably 4 Dunknown to completion of cause aft? (Specify) d unk cor Rural Route Number, 23 Maugans A mer as stated, and due to the cause(s) (Month, Day, Year)

Physici		1 - State Registra MEND#5perINF1/ 1. Decedent's Name (First, Middle, Last	11/05,BMW,MCCo		f Death	2. Date of Deat	g. No	CUI	3. Time o) U
	ian		dsor Jr.			Month January	Day	Year 2005	6:00	A A
/Medic		4a. Facility Name (If not institution, give		4b. City. Towr	n, or Location of Dea			nty of Death	0.00	A
Examir	ier	Manor Care of Beth			esda			gomery		
uneral irector		5. Social Security Number 6. Se		irthday) If Under 1 Ye Yrs. Months Day		. (Month, Day,	Year)	9. Birthp Coun	lace (State o	or Fore
		Usual Residence of Decedent 10a. State 10b. County		wn or Location		Dec. 26	, 1922		yland Od. Inside C	ity Limi
8e-f sho	ctor	MD Montgome	ery	Poto					1 🗆 Yes	-
23a or 2	al Dire	10e. Street and Number 10612 Democracy I	⊿ane	10f. Zip Cod	20854		-	of What Coun d Stat		
nd other than "netural", or liems 23a or 28e-f show event, it e Maarcal Examinat must be natified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1∑IYes 2 ☐ No If Yes, Give Year or Dates: WWII	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puel No Specify:	Specify Yes or No- to Rican, etc.)		ace - Americ lack, White, cify: Wh		
an "neture Modical E	Completed	15. Decedent's Edu (Specify only highest grad	ication 16s le completed) College (1-4or 5+)	a. Decedent's Usual Oci (Give kind of work do. life. DO NOT use ret	ne during most of wo	orking	16b. Kind of	Business/Inc	dustry	
artha.	ПO		2	Owner			Gas St	tation		
and mental hygiene. Is marked other than eumetic evant, it is m	To Be (17. Father's Name (First, Middle, Last) Charles E. Windso	or Sr.			me (First, Middle, N e Dixon	faiden Suma	ame)		
of Health and Menta f itam 27 Is markad r other treumetic e		19a. Informant's Name/Relationship (T) Carol C. Windsor/	100	b. Mailing Address (Stre 10612 Democ					Code)	
tam tam		20a. Method of Disposition	20b. Place	of Disposition (Name of				n - City or To	wn, State	
Important: If its any Injury or ot once.		1 🎖 Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ery, crematory`or other p of Heaven	Jan 20	uary 6		r Spri)
Import any In		21. Signature of Funeral Service Licens 1 PACY A. Fun		22. Name and Ad		DeVol Fun aithersbu	eral H	Home,1 MD 208	0 East 77	t
ysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	not enter the mode of o		c or respiratory arre	st,	Н	Approximat Interval Bet Onset and	ween
Medical aminer		resulting in death)	Due to (or as a consequence	of):						
nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):						
physician and s the burial-transit	icai Exa	that initiated events resulting in death) Last	Due to (or as a consequence	• of):						
attending ph I for use as th	Physician/Medi	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal deat	h 3⊟Ectopic pregna	ncv			Date of delive		
# C	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)				Month	Day '	Year
by the a		Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause	given in Part I.	23e. Did tob		ntribute to th		
gned by the se detached	ted by							Were autor	sy findings	available ause of
ate has been signed by the page 2 should be detached						24a. Was an autopsy perform	ed?	prior to con death?	2 🗆 No	
ate has been signed by the page 2 should be detached	e Completed	25. Was case referred to medical axaminer?				autopsy perform 1 Yes 2 ath (Check only one	ed? No	prior to con death? 1 \(\sum \text{Yes}\)	2 🗆 No	
s certificate has been signed by the director, page 2 should be detached	Completed	examiner? 1 ☐ Yes 2 X No	Hospital: 1 □ Inpatient 2 □ ER/O	dipatient 3 DOA	Other: 4 Nursing I	autopsy perform 1 Yes 2	ed? No	prior to con death? 1 \(\sum \text{Yes}\)	2 🗆 No	
". After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed	examiner? 1 Yes 2 No 1 Yes 2 No 1 Manner of Death 1 Natural 5 Pending investigation	1 Inpatient 2 ER/O	Time of Linjury 28c. In	Other: 4 Nursing I	autopsy perform 1 Yes 2 ath (Check only one	ed? No	prior to condeath? 1 Yes	2 🗆 No	
 funeral director, page 2 should be detached	To Be Completed	examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending	1 Inpatient 2 ER/O	Time of Injury M 1	Other: 4 Nursing Nursi	autopsy perform 1 Yes 2 ath (Check only one) Home 5 Residen	Ned? No	prior to condeath? 1 Yes ther (Specify	2 No	ber,
Funaral Diractor. After this centificate has been signed by the ely filled in by the funeral director, page 2 should be detached.	Certification: To Be Completed	examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, I	Time of Injury M 28c. In Injury M 1 arm, street, factory, office 19e, death occurred at the	Other: 4 Nursing Figury at York? Yes 2 No	autopsy perform 1 Yes 2 ath (Check only one Home 5 Resider 28d. Describe how 28f. Location (Str. City or Town,	winjury occu	prior to condeath? 1 Yes ther (Specify urred	2 No	
Funded Director. After this certificate has been signed by the funded in by the funeral director, page 2 should be detached	To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Exami	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, I building, etc. (Specify) sician: To the best of my knowledgner: On the basis of examination a	Time of linjury M 1 arm, street, factory, office 199, death occurred at the nd/or investigation, in m	Other: 4 Nursing Figury at York? Yes 2 No	autopsy perform 1 Yes 2 ath (Check only one 1 Yes 2	w injury occu	prior to condeath? 1 Yes ther (Specify urred	2 No Route Num ated. the cause(s	
n. After this certificate has been signed by the funeral director, page 2 should be detached	edical Certification: To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, I building, etc. (Specify) sician: To the best of my knowledger: On the basis of examination a and manner stated.	Time of Injury M 1 arm, street, factory, office 19, death occurred at the nd/or investigation, in m 29c. Lice	Other: 4 Nursing Nursing Nurvat Vork? Yes 2 No Dee	autopsy perform 1 Yes 2 ath (Check only one) 1 Resider 28d. Describe how 28f. Location (Str. City or Town, a, and due to the caurred at the time, da	winjury occurrence and Num State) seet and Num State) use(s) and numerical and place	prior to condeath? 1 Yes ther (Specify urred	2 No Route Num ated. the cause(s	

05-00288 Dale Weedon RJD

Physicia	ın	Decedent's Name (First, Midd Dale	fle, Last)	Wee	edon					2. Date of Dea January		20 0%	3. Time of Death 2116P.	
/Medic Examin		4a. Facility Name (If not institution		in in		4b. City,	Town, or	Location of				ounty of Death		
LXamiin	=1	Washington Co					rsto					hingto		
Funeral Director		5. Social Security Number 219–74–2939	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 46	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Jan. 26			nplace (State or Foreign untry) rland	
land		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
the Marylan 28e-f show	ctor	Maryland Washi	ington	Hag	gersto	wn							1 ▼Yes 2 No	
th with the 23e or 28 In Lean	Funeral Directo	10e. Street and Number 124 West Frank	lin Street			10f. Zip	Code 2174	0		1	l0g. Citize	en of What Col	untry?	
ol, o	þ	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce	rried Armed For	2 [≛ No e		Was Deced If Yes, spec 1 ☐ Yes		ispanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: B1		
"nature	Completed		nt's Education est grade completed)		(Give	dent's Usua kind of wor	rk done a	lurina mos	t of workir	ng	16b. Kin	d of Business/l	ndustry	_
within liene. r than	omp	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT US U tomo		•	iler		Aut	omotive	Industry	
be filad tal Hyg rd othe event,	Be	17. Father's Name (First, Middle Edward R.	, Last) Weedon						er's Name	(First, Middle, E. C				
should nd Mer marke matic	ို	19a. Informant's Name/Relation			19b. Mailii	na Address	(Street a			l Route Number			in Code)	_
and 2 s alth ar 127 le er trau			n/ Brother		1					erstown			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
iges 1 and of the correction or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		1 -	Place of Dispo cemetery, crea	nsition (Name	ne of ther place	e)	D	ate	20c. Loc	ation - City or 1	Town, State	
nit. Pa artmer ortant: injury injury	ï	'4 □ Donation 5 □ Other (Ho	pe Hil	1 Cem	eter	y 1		/2005				-
Depa Impo eny iu		* KolyMQ	Je						DLa	uffer F ke, Fre			_	
hysician		23a. Part Peter the disease, of shock, or heart failure. Lie Immediate Cause (Final disease or condition		aused the death ach line. cylate	h. Do not ent	er the mod	e of dying						Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):									
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscass or injury	b. Due to (or as a conseq	uence of):									
and and II-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):									_
ate be axecuted hysician and the burial-transit	ical E		d											
artificat ing phy e as th	ed .	IF FEMALE:												_
Attending Physicien: The law requiras that the death cartificate be axecuted refeath. The think receives the sector. After this certificate has been signed by the attending physician and estor. There this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		inth 2 ☐ Feta ant at time of d	l déath 3[∃Ectopic pr ∃ Other (sp					23	3d. Date of deli- Month	very Day Year	
w requiras that been signed b should be deta	þ	Part II. Difher significant condif	ions contributing to de	ath but not res	ulting in the u	nderlying c	ause give	en in Part I				e contribute to	the cause of death?	
The law requate has been page 2 should	Completed									24a. Was a autops perform	SV	24b. Were aut prior to c death? 1 1 Yes	copsy findings available ompletion of cause of	
yeicien: The I is certificate ha director, page	Be	25. Was case referred to medic examiner?					l Out		of Death	(Check only on				
Phye	<u>ا</u> د	Yes 2 No 27. Manner of Death		npatient 2 🛭 of Injury h, Day Year)	ER/Outpatier 28b. Time o		28c. Injury Work	4 🗀 🖂		ne 5 Reside			ify)	-
arth. arth. nr: Afte	atior		tigation $1-11$		Injury	M		<br Yes 2 X		ubject			rug	
To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 ☑ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286, Place	of Injury - At hong, etc. (Specifical Concession)	ome, farm, str	reet, factory	, office		Ap.	28f. Location (Si City or Town t.3 Hap	treet and n, State) erst	Number of Rule 124 W. own Ma	Franklin S aryland	t
e Hospi 24 hour e Funer letely fill	Medicai	29a. Certifier 1 Certify Chack only one)	ing Physician: To the Il Examiner: On the ba and mann	isis of examina	wledge, deat ition and/or in	h occurred vestigation	at the tim , in my or	ne, date an pinion, dea	nd place, a th occurre	and due to the ca	ause(s) a ate and p	ind manner as place, and due	stated. to the cause(s)	
	Me	29b. Signature and title of certification	er			290	. License	number		2	9d. Date	signed (Month	, Day, Year)	
To th To th comp											_	4.0		
To th To th comp		1 Any A	i, m.D)		0	C.M	1.E.			Janu	ary 12,	, 2005	

			1 - For Stata Registrar	State o		id / Depa		t of H	ealth a	and M	lental Hyg		2005	015	05
			1. Decedent's Name (First, Middle, La.	st)			-	·			2. Date of Dea	th	Vaar	3. Time of	Death
	Physici /Medio		BERMA BLAINE YER	KEY							JANUARY	13	2005	0443	М
	Examin		4a. Facility Name (If not institution, give		mber)				Location o	of Death			County of Death	1	
			MEMORIAL HOSPITAI		7 Ago //g use	In me to inthe alone.		MBER 1 Year	LAND If Under	24 Hrs	O. D		LEGANY	1 (0)	
	Funeral Director		5. Social Security Number 6. S 2 3 4 - 1 4 - 3 8 8 5	ex 1XIM 2□F	7. Age (In yrs. 87	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 1 1 / 26 / 1	Year) 917	9. Birth Cot	place (State or intry)	· Foreign
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside Cit	a. Limito
	sho	ō		·m										1 Tyes	
	the N	Director	WV GRAN	1	MA	YSVILL	10f. Zip	Code			1	Oa Citiz	en of What Cou	intry?	
	3e or		Route 42					26833	}			-g	USA	,	
	death ms 2	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.				gin? (Spe	ecify Yes or No- Rican, etc.)	1	4. Race - Amer		
٥	or ite	Fu	1 Never Married 2 Married	Amned Fo 1 X Yes If Yes, Giv	2 🗌 No		ires, speo 1 □ Yes	**	n, mexican Specify:		Hican, etc.)		Black, White	, etc.	
9500-61212	d within 72 hours after death with the Marylar joens r then "neturel", or items 23e or 28a-f show I'r e Madical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or D	ates: WWII									HITE	
7	"net	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ation during most	t of worki	ing	16b. Kir	d of Business/li	ndustry	
7	within ene. then	duc	Elementary/Secondary (0-12)	College (1	1-4or 5+)		DAINE					HURCI	H OF THE	BRETHREN	
	othe ent.	Be C	17. Father's Name (First, Middle, Last)								(First, Middle,				
<u>a</u>	uld be Aenta rked tic ev	To B	ERNEST YERKEY						RI	EBEC	CA STURI	ER			
Maryland	2 should and Men le marke eumatic		19a. Informant's Name/Relationship (Турө, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Number	, City or	Town, State, Zi	ip Code)	
	rt 27		CAROL V. YERKEY/	WIFE	1001 5						, WV 268				
Baltimore,	Pages 1 and Heat of Heat of Heat of Heat or othe		20a. Method of Disposition 12 Burial 2 Cremation 3	Removal from	State 20b. F	Place of Dispo cemetery, crer	natory or o	ne of ther plac	θ)	L	Date	20c. Loc	cation - City or T	own, State	
			' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		LAF	MANSVI							MANSVIL	•	
g	permit. Departr Importe any inju		21. Signiture il Funeral Service Licer	JA	111	,	2. Name an			301	ARPELLI				
	-		23a. Part1. Enjer the disease, or com	plications that of	aused the deat						CUMBERLA or respiratory arr		MD 2150	Approximate	
	Physician		shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on e	uren line. URED HI									Onset and D 23 DAYS	reen leath S
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):									
Á		Jer	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oua to	paerich e se 16)	mence of):									
1,	acuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
/60,	ate be executed hysician and the burial-transit	E E	resuming in deam) case	Due to	(or as a conseq	uence of):									
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ВОХ	death certificate e ettending phys d for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							2	3d. Date of deliv	/ALV	
	death e ette	Physician/Med	in the past 12 months?	4□Pregn	oirth 2 ☐ Feta nant at time of d		Ectopic pr Other <i>(sp</i>						Month	<u> </u>	ear
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ecords, l	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to di	eath but not res	ulting in the u	nderlying c	ause give	en in Part I.				se contribute to	1	eath? nknown
ပ္ပ	aw re-	Completed									24a. Was a		24b. Were aut	opsy findings a	vailable
Ľ	The ate h	Com							_		autops perform		death?	ompletion of ca 2 ☐ No	use of
VItal	Physicien: this certific ral director,	Be (25. Was case referred to medical examiner?								(Check only on	Θ)			
0	Phyei this c	은	1 X Yes 2 □ No			ER/Outpatier		A Cthe	ar: 4 □ Nu	rsing Hor	me 5 🗆 Reside	ence 6	□Other (Speci	ify)	
	tel tel	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending 1 □ Accident investigation	28a. Date Dec	20°04°	7:30P	M _M	8c. Injury Work	rat (? ∕es 2.∑X		28d. Describe ho Patient				
DIVISION		tifica	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At he	ome, farm, str	eet, factory	, office		2	28f. Location (St City or Town	reet and	Number or Rur	al Route Numb	70 <i>r</i> ,
5	spital or ours afte nerel Diri	Cer			taurant	,,				JI.	Grant C	,	y West	Virgin	ia
	Hos Fur tely	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Madical Exam	niner: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or in	n occurred vestigation	at the tim	e, date an	d place, a th occurre	and due to the ca ad at the time, d	ause(s) a ate and	and manner as splace, and due	stated. to the cause(s)	
	To the within 2	Me	29b. Signature and title of certifier				290	. License	009T5	7	2	od. Date	1 ^{signed} 2005	Day, Year)	
			Etal hong	/ M. in	DPTY	Men	0								
	6		30. Name and address of person who					DDT 1	NID 3	m 11	502				
	2	10	PAUL SNOW, M.D. 12	4 WEST	THIRD S	TREET			ND, M	1D 21	.502				
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 2005 32. Figistrar's Signature												

		1 - For State Registrar	State	of Maryland /		tment of H		Mental Hy	giene	005	01506
Physici		Decedent's Name (First, Middle DOUGLAS	e, Last)			Aus	STIN	2. Date of D Month	Day	Year 2005	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution		· ·		b. City, Town, or				ounty of Death	
		Johns Hopkins						MARYLA			
Funeral Director		5. Social Security Number 214-38-5435 Usual Residence of Decedent	6. Sex 1 ★ 2 ☐ F	7. Age (In yrs. last		f Under 1 Year Months Days	Hours Min		irth (ay, Year) 6 , 194	12 Vir	place (State or Foreign ginia
/land		10a. State 10b. County		10c. City, To	own or Locat	tion				1	0d. Inside City Limits
a-fsh	ctor	MD Bal	timore		Ess	sex					1 ☐ Yes 2 X No
or 28	Director	10e. Street and Number	- D D	3		10f. Zip Code			-	n of What Cour	ntry?
eath v	Funeral	313 Stemmer		cedent Ever in U.S.	13. Was	21221 s Decedent of Hi		Specify Yes or N	USA	A I. Race - Americ	ean Indian.
ine; Ivially lail of I.Z. I.Z. DOOO	by Fun	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F	Forces? 2 ∑K lo iive	If Ye	es, specify Cubai Yes 2 XNo	Specify:	rto Rican, etc.)		Black, White,	etc.
72 hou		15. Deceden (Specify only highes	t's Education	16	6a. Deceden	it's Usual Occupa	ition	arkina	16b. Kind	d of Business/In	dustry
d within 7 giene. or then "r	Completed	Elementary/Secondary (0-12)	Ť	(1-4or 5+)		d of work done d NOT use retired; nnican)	SIKING .	Pes	t Cont	rol
all the file of the ed others event,	Be	17. Father's Name (First, Middle, Otis Austi						ame (First, Middle	e, Maiden S	umame)	
should should nd Me mark maric	2	19a. Informant's Name/Relations		1	9b. Mailing A	Address (Street a		Brown	ber, City or	Town, State, Zip	Code)
ING 2: alth ar 27 Is ar trau		Shirley Austi	n /wife		•	Stemme					
es 1a of He of He of other		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation	3 □ Bernoval from	20b. Place	of Disposition	on (Name of cory or other place CEMETER	1/2	Date 1 / 0 5		ation - City or To	
t. Pages trment of l rtent: If it		'4 □Donation 5 □ Other (S	pecify)	Oak				·		imore	
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		21. Signature of Funeral Service	y (on	nelli	1	<u>300 Ma</u>	ice Ave	e. Balt	imore	ralHome	eofEssex 1221
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death_ Deach line.	o not enter t	the mode of dying	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	epsis			_				
Examiner				o (or as a consequence CUTROPEN (A							
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U.	(or as a consequent							
icate be executed physician and sthe burial-transit	Examiner	Cause (Disease or Irijury that initiated events resulting in death) Last		NCREATIC o (or as a consequent		LHOMA					
e be ex	dlcal E		d	·							
ntificat	Medi	IF FEMALE:			-						
Boath certific eattending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnancy birth 2 Fetal dea	ath 3 ⊟Ec	topic pregnancy			23	d. Date of delive Month	ery Day Year
the de	yslc	1 ☐ Yes 2 Mo 9 ☐ Unknown	9□ Unk	nant at time of death nown	5 01	ther (specify)		-			
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	ons contributing to	death but not resulting	g in the unde	erlying cause give	n in Part I.				ne cause of death?
w requir been si should I	eted							1000000	Yes 2		
vital nec sicien: The law certificate has b lirector, page 2 s	Completed							24a. Wa auto peri 1 ☐ Yes	s an opsy ormed?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available impletion of cause of
sten: dentifica	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only		10163	200 140
Physic this ce al dire	은	1 ☐ Yes 2 No				3□ DOA Othe	4 [Nulsing	Home 5 ☐ Res			γ)
ding F After funera	tlon:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	9	of Injury 28t nth, Day Year)	b. Time of Injury	28c. Injury Work	at ? ∕es 2 ∐No	28d. Describe	how injury	occurred	
rational Or vital in rate at the day. The er death. rector: After this certificate he by the tuneral director, page	ertification:	2 Accident Investig	not be 28e. Plac	ce of Injury - At home, ding, etc. (Specify)				28f. Location City or To	(Street and own, State)	Number or Rura	l Route Number,
pitel o	O	450.464						1			
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On the	ne best of my knowled basis of examination nner stated.	dge, death oc and/or invest	ccurred at the tim tigation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time	cause(s) a , date and p	nd manner as st lace, and due to	ated. the cause(s)
To t To t	Σ	29b. Signature and title of certifie	10			29c. License				signed (Month,	
1 ^		30. Name and addless of person	0	Lea of death (Item 23:	a) (Tuna D-i-		- 600	171.7-171	JANU	ARRY 20,	2005
U				use of death (Item 23)	_		KIH WO	LFE ST	LEET, F	PALTIMORY	E MD 21287
Sta		31. Date filed (Month, Day, Year)	32	gistrar's Signature		1					
Registi	ar	JAN 2 4	2005	Rolling St.	103	we					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State amend item 11 per hus. 6843 5/605 amh
Registrar
Registrar
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day BROWNI MARIN JANUARY 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Northwest Hospital Rendallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) North Carolina 1 M 2 F 3 139-64-7581 Jan 9 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baitmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4800 Vellow wood Ave 21209 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 Yes 2 No Specify: Specify: Black 3 Notwood 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realtor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Charlie AIKins Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Kirby-Swapshur 9008 Bree 3 wird Tirraise M304 Greenbeet MD

Method of Disposition

Date 20c. Location - City or Town, State

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Oakview Cemetary Jan 25, 2015 Badin, N.C. `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Ficility Ringled a Hicysen Fur 108, W. north ave. 21. Signature of Funeral Service Licensee Funcial Home Rinald a Grayen Breto md 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate

Fnysician /Medical **Examiner**

permit. Page Department of Importent: If any injury or once.

Physician

/Medical

Examiner

Director

Be Completed by Funeral

10a. State

MD

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland neal of Health and Mental Hyglene. and the filled 72 is marked other then "naturel", or Itams 23s or 28s-f show ant: if Item 27 is marked other then "naturel", or Interface in Italia and its any or other treatmatic event, Ita Maryland Estantisation in Italia and I

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funerel Director: Afte completely filled in hours.

to the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

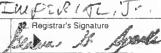
Examiner	Se if a ca Ca tha res
y Physician/Medicai	IF 23
y Ph	Par
: To Be Completed by	
o Be	25.
rtification; To	27.

	shock, or heart failure. List only	one cause on each line.		, 0			rvai Between
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	eme Co	Litis		Ons	set and Death
niner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	b. Due to (or as a Insee	11				
dicai Exan	that initiated events resulting in death) Last	Due to (or as a consect d.	,				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 0 9 □ Unknown	al death 3 Ectopic		2	23d. Date of delivery Month Day	Year
ed by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 Tyes 2	se contribute to the ca	
Somplet					24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy finding prior to complet death?	tion of cause of
Be (25. Was case referred to medical			26. Place of De	ath (Check only one)		
ToE	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐ I	DOA Other: 4 Nursing H	Home 5 ☐ Residence 6	Other (Specify)	
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury		
Medical Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)		ite Number,
edicai	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated, place, and due to the	cause(s)
M	29b. Signature and title of certifier	is 5	2	29c. License number DUYJOS		e signed (Month, Day,	

NWHE

State Registrar

31. Date filed (Month, Day, Year)



o completed cause of death (Item 23a) (Type, Print)

JAN 2 4 2005

			1 - For State Registrar	State of Ma	ryland / Der Ce	artmen ertificat			ind M	lental Hy	gien Reg. N	211	05	01508
I	Physici /Medic		Decedent's Name (First, Middle, Las Glenda Yvon:		У					2. Date of Do Month JANUA	D		Year 2005	3. Time of Death 8:52 P M
	Examir	er	4a. Facility Name (If not institution, give 6000 SAMARITAN 5. Social Security Number 6. Se	HOSPITAL	(In yrs. last birthda	BAL	TIM	Location of		C. Data of Bi		A 1	of Death	(0)
	Funeral Director		218-62-3245 10 Usual Residence of Decedent	M 2 12 F 5	O Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D. July	1, 1	954	Mary	place (State or Foreign offy) yland
	he Marylar 8a-f show	ector	Maryland N/A		10c. City, Town or Balti	more								10d. Inside City Limits 1X Yes 2 ☐ No
	ath with t	Funeral Director	10e. Street and Number 4202 Hamilton			10f. Zip 2	1 2 0 6				10g. C	USA'	What Cour	itry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event. The Medical Exacilinat must be natified at ance.	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:		. Was Deced If Yes, spec 1 Yes	cify Cuban	spanic Orig n, Mexican, Specify:	in? (Spe Puerto i	cify Yes or No Rican, etc.)	0-		e - Americ ck, White, 31acl	
21215-(d within 72 h giene. er then "netu the Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5- 3.5 Year	7 0 - 1-	edent's Usua e kind of wo DO NOT us DO 1 T			of workii	ng			e Sc	
Maryland 2121	ould be file Mental Hy larked othe	To Be C	17. Father's Name (First, Middle, Last) Harold William					Vir	gın	(First, Middle lia Ca	rte	r 		
, Mar	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (T Robert Bradby/H	ype, Print) [usband				nd Number on Av	or Rura 7enu	ie Bal	er, City tim	or Town, ore	State, Zip Md	21206
altimore,	Pages 1 tment of H tant: If fter ijury or oth	1	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 1 `4 □ Donation 5 □ Other (Specify))	20b. Place of Dis cemetery, cr Mt. Zio	n Ce n	ther place, eter	y 1	/20		Bal	timo		Maryland
Bal	Departiment Depart		21. Signature of Funeral Service Licens		1	5240	Reis	sters	stow	n Rd	Bal	ris	Fun	eral Home Md21215
>	Physician /Medical		23a. Partif. Enter the disease, or comp shock, or heart failure. List only of Immédiate Cause (Final disease or condition resulting in death)	a. INTRAC	EREBR	ALH					arrest,			Approximate Interval Between Onset and Death
8/60,	cate be executed physician and sthe burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPER Due to (or as a	TENGIO consequence of):	N								
O. Box 6	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Inknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 9 ☐ Unknown	Petal death 3	□Ectopic pr □ Other (sp		<i>111</i>				23d. Dat Mor	e of delive	ory Day Year
rds, P.	quires that the de in signed by the a uld be detached f	by	Part II. Other significant conditions co	ntributing to death bu ETES ME	_	underlying c	ause given	in Part I.						e cause of death?
Vital Hecords,	100 577	Completed	OBESITY							24a. Was auto perfo		p d	rior to con leath?	psy findings available npletion of cause of
	sician: The l certificate ha irector, page	o Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		-5-4	Other			(Check only	one)			
ion of	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	1-	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time		8c. Injury a Work?	4 🔲 Nuis	2	ne 5 Resi)
Division	Ital or Attendi rs after death, ral Director; A led in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, s (Specify)	treet, factory	, office		2	8f. Location (City or To	Street ai wn, State	nd Numbe 9)	er or Rural	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	29a. Certifier 1	sicien: To the best of ner: On the basis of and manner stat	examination and/or i	nvestigation,	in my opir	nion, death	place, a occurre	nd due to the d at the time,	cause(s date an) and mai d place, a	nner as sta and due to	ated. the cause(s)
	To To com	Σ	29b. Signature and title of certifier	nous	MD	1	License r							Day, Year)
r			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type	Print)	=> 1	bi-V/N	12.	AITI	MAN	E 1	Ky I	4,2005 21239
	Sta Registr		VIII UII UII UII U	32. Redistrai	's Signature	Sperke	11/12	(1)	121	11/1/	VIDK	L, 10	10 .	-1651

DHMH 17 Rev 1/2001

CLENDA

BRADBY

05-	ert Lee 00479	Br	radley Please Type or Print in Black Ind amend item#5, per, FH, G640, 2723/05 State of Maryland / Depa	ielible Ink. Ensure All	Copies	Are L	egible.	
crn				tificate of Death		Reg. No.	005	01509
1	Physicia	an	Decedent's Name (First, Middle, Last) Robert Lee Bradley		2. Date of De Month Januar	Day	2005	3. Time of Death 11:53 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Januar	-	ounty of Deeth	
			1928 Fleet Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	3. Date of Bir	*b	N/A	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) 120-52-3912 77. Age (In yrs. last birthday) 155 Yrs.	Months Days Hours Min.	04/21/	1949	Mary	ntry)
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	eation				10d. Inside City Limits
	e Mary Be-f sh	ctor	Maryland N/A Baltimore					1 Yes 2 □ No
	with th	Directo	100. Street and Number	10f. Zip Code 21231			en of What Cou ed Stat	
	ems 23	Funeral	1915 Bank Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If	ZIZJI Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R	ify Yes or No		Race - Amer Black, White	can Indian,
36	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-f show he Modical Examiner must be notified at	by Fu	1 X Never Married 2 Married 1 Yes 2 X No	☐ Yes 2 No Specify:	, , , ,		pecify: Whi	
5-00	72 hou neture	eted	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working	7	16b. Kind	of Business/Ir	
121	within iene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpen	00 NOT use retired)		Cons	structi	on
nd	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		, Maiden S		-
IZ la	should nd Men marke imatic	2	James B. Bradley Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Lillian 3			Town, State, Zi	p Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione Importent: If item 27 is marked other then "neturel", or items 23s or 28e-1 show any injury or other treumetic event, the Medical Examinat must be restified at once.			Grande View Drive	-			
nore	ages 1 nt of H t: If Item / or oth		1 A Burial 2 Uremation 3 UHemoval from State	atory or other place)			ation - City or T	
altin	mit. P partme porten; y injur;			orial Garden 1/26/ Widang Add Weber Funer			ir, Mar .A.	yraud
m	50 E 2		23a. Part1. Enter the disease, or complications that caused the death. Do not enter	11 S. Chester Stree			e, Mary	land 21231
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		respiratory a	11031,		Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	AETHORICHAGE				
		Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	4 ANEURYSM				
	ecuted and I-transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
760,	e be ex	calE	d.					
89 x	eath certificate be ex attending physician a for use as the burial	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			- 1		
Division of Vital Records, P.O. Box 68760,	wrequires that the death certificate be ex been signed by the attending physician : should be detached for use as the burial	Physician/Medical E	236. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)		23	d. Date of delive Month	Pery Day Year
P.0	law requires that the as been signed by the should be detached.	Phys	9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the un	Identying cause given in Part I	23e Did t	obacco usi	e contribute to	the cause of death?
rds,	quires t in signe	ed by				Yes 2		
eco	faw rec las bee	Completed			24a. Was	psy	24b. Were aut prior to co	opsy findings available ompletion of cause of
E H	sicien: The faw s certificate has b lirector, page 2 s	e Con	25. Was case referred to medical	26. Place of Death	112KYes	ormed?	death? 1.★Yes	2□ No
Ž	Physicien: this certifica ral director, p	To B	examiner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other: 4 Nursing Hom			VOther (Speci	mat scene
ono	Attending Property. Attending Property. Attention to the funeral	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	3d. Describe	how injury	occurred	
ivisi	r Atten ter deal rector by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office 28	3f. Location (City or To	Street and wn, State)	Number or Rui	al Route Number,
D	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	nd due to the	cause(s) a	nd manner as	stated.
	To the Hospitel of within 24 hours a To the Funeral Completely filled it	Aedical	(Check only 2 Medical Examiner: On the basis of examination and/or inv one) and manner stated.	estigation, in my opinion, death occurred	d at the time,	date and p	lace, and due	to the cause(s)
	To vith	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.			signed <i>(Month</i> ary 21,	
4	3		30. Name and address of person who completed cause of death (Item 23a) (Type, F		nore, 1			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 2005 L. Registrar's Signature	lis				
			and the state of t					

			State of Mar State Registrar		artment of rtificate o		d Mental Hyg	iene2 () () 5 eg. No.	01510
	Physicia	_	Decedent's Name (First, Middle, Last)				2. Date of Dear Month		3. Time of Death
	/Medic	al	LEO M. BROZNOWICZ				JANUAR	1	
	Examin	er	4a. Facility Name (If not institution, give street and number) JNIVERSITY HOSPITAL			n, or Location of D $MORE\ CIT$		4c. County of Dea	th
				(In yrs. last birthday)	If Under 1 Ye			9. Bir	thplace (State or Foreign
	Funeral Director		212–11–1451 1 [™] ^{1™} ^{2□} F	19 Yrs.	Months Day		Hrs. 8. Date of Birth (Month, Day) 09/18/1	Year) C	ountry) Cyland
			Usual Residence of Decedent		1		105/15/1	705 1301	
	ylan		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fe	cto	Maryland	Baltimore	2				1 X Yes 2 □ No
	ih th or 28	Funeral Directo	10e. Street and Number		10f. Zip Code			0g. Citizen of What C	
	23e	-a	321 South Duncan Street			1231		United Sta	
	tama	nue	11. Marital Status 12. Was Decedent Ev Armed Forces?		Was Decedent of If Yes, specify C	of Hispanic Origin' Suban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	
36	rs afte	by F	1 Never Married 2 Married 1 1 Yes 2 Maried 1 1 Yes 2 1 Maried 1 1 Yes 3 2 1 Maried 1 1 Mar		1□Yes 2🖔 N	No Specify:		Specify: Wh:	ite
ခု	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28e-f ehow he Medical Evantinet must be notified at	edt	15. Decedent's Education	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Business	
7	n "ng	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	kind of work do DO NDT use ret	ne during most of tired)	working		
2	d with	E O	12	Appre	entice S	Steamfitt	cer	Plumbing	
פ	a file al Hyg othe vent.	BeC	17. Father's Name (First, Middle, Last)				Name (First, Middle, i	Maiden Sumame)	
<u>Ja</u>	Menta Menta arked aric e	To	Leo M. Broznowicz			Anita	a Rauh		
Maryland 21215-0036	and and is mu		19a. Informant's Name/Relationship (Type, Print)				r Rural Route Number		
	and ealth m 27 her tr		Anita Rauh- Mother	3ZI S			Date Date		
O	ges 1 if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crei	matory or other i	place)	100	20c. Location - City of	
Baltimore,	tmen tant: tant:		' 4 ☐ Donation 5 ☐ Other (Specify)				01/21/05		Maryrand
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural; or itema 23e or 28e-f ehow any injury or other traumatic event. The Medical Evarifier must be relitived at Once.		21. Signature of Funeral Service Licensee Kathleen a. Weber Ct	40	01 S. Ch	nester St	uneral Home treet, Balt	cimore, MD	
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line						Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	& Nich h	yupus	with C	npleatin		Onsot and Death
п	/Medical Examiner		resulting in death) Due to (or as a	consequence of):	1				
В	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):					
	bed nsit	Examiner	Cause (Disease or injury	consequence or).					
	xecu and al-tra	xar	that initiated events c.	consequence of):					
8760,	The law requires that the death certificate be exacuted ate has been signed by the attending physician and paga 2 should be detached for use as the burial-transit	cal	d						
68	ifficat g phy as th								
ŏ	leath certific attending pl	N/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2		∃Ectopic pregna	ncv		23d. Date of de	•
œ.	that the death ed by the atte detached for	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at ti		Other (specify			Month	Day Year
P.O.	at the by the	Phy	9 Unknown				on- Dida		a the same of death?
	res tha Igned be del	by	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause	given in Part I.		bacco use contribute t es 2□No 3□P	robably 4 Unknown
Records,	w require been sla	Completed					_		
ec	e law has b ya 2 sh	npie					24a. Was a autops	sy prior to	utopsy findings available completion of cause of
		Cor						2□No 110Ye	s 2 No
Vit:	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? **Total			Other	Death (Check only or		
of Vital	Physician: r this certificatal director, i	To To	27. Manner of Death 28a. Date of Injury	28b. Time o	IL JUDON	4 🗆 :40131	ng Home 5 Reside	ence 6 LIOther (<i>Spe</i> ow injury occurred 4	acity)
On	ding h. After fune	tion	1 □ Natural 5 □ Pending (Month, Day) 2 □ Accident investigation (Month, Day)	Year) Injury		njury at Work? 1 □ Yes 2 🕱 No	persent	a yeelich	in web wh
Division	i or Attending after death. I Director: After d in by tha fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur	y - At home, farm, sti	reet, factory, offi	ice		treet and Number or F	
<u>S</u>	al or	Certification:	4 Homicide building, etc.	(Specify)			Avad a	in State 4215	-grand Run
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director,	edicai (29a. Certifier (Check only one) Certifying Physicien: To the best of and manner state and manner state	examination and/or in					s stated.
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Lic	ense number		9d. Date signed (Mon JNAUARY 19	
	10		30. Name and address of person who completed cause of	ath (Item 232) /Tun-	Print)				
	Ψ		THE WOOM ME MIKING	111 PF	ENN STRE	EET, BALT	ΓΙΜΟRE, MAI	RYLAND 2120	01
	Sta	te	31. Date filed (Month, Day, Year) 32-Registrar	's Signature					
	Registr		JAN 2 4 2005 Line	It has	refer				

			For State Registrar	State of	Maryland / [rtment of H		ind Me		giene Reg. No.	005	0 5	
	Physici	an	1. Decedent's Name (First, Middle	lle, Last)					2	2. Date of De Month	ath Day	Yea	3. Time of Death	
	Physici /Medio		H. Diane Bri							Januar	y 19	, 2005	1630 ^M	1
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or		f Death			County of De		
			Shady Grove 5. Social Security Number		Hospital . Age (In yrs. last bin	thday)	Rockvil If Under 1 Year	le If Under 2	24 Hrs. s	B. Date of Birt		ontgom	ery Iirthplace (State or Foreig	N7
	Funeral Director		577-52-5827	1 □ M 2 🕅 F		Yrs.	Months Days	Hours	Min.	Month, Da Jan. 3	y, Year)		cbraska	,,
			Usual Residence of Decedent							Jan. J	, -,	750 NC	DIABRA	
	anylar show	_	10a. State 10b. County	y	10c. City, Town	n or Lo	cation						10d. Inside City Limits	
	8e-1	Director	Maryland Montg	gomery	Rockvi	11e							1 ☐ Yes 2 ☐ No	
	with the	2	10e. Street and Number				10f. Zip Code					zen of What	•	
	eath	era	12505 Knightsb		ent Ever in U.S.	13 V	20850		in? (Speci	ify Yes or No		ted St	ates	
"	r Hend	Funerai	1 ☐ Never Married 2 📉 Mar	rried Armed Ford	es? [X]No		Vas Decedent of Hi Yes, specify Cuba		, Puerto Ri	can, etc.)		Black, Wi		
8	hours after death with the Maryland tural', or Items 23e or 28e-1 show at Examinar must be notified at	b	3 ☐ Widowed 4 ☐ Divorced	d If Yes, Give Year or Dat	es:	1	☐ Yes 2X No	Specify:				Specify: V	Vhite	
Maryland 21215-0036	72	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a.	(Give	ent's Usual Occupa	luring most	of working	7	16b. Ki	nd of Busines	ss/Industry	
121	within ene. than	ם	Elementary/Secondary (0-12)	College (1-4			OO NOT use retired)			0	77		
2	nt, the		17. Father's Name (First, Middle,	Last)		Home	emaker	18 Mother	r's Name (First, Middle,		wn Hom	e	
an	D to D	To Be	Leonard E. Kee							nette				
ary	2 should be to and Mental I is marked or reumatic eve	-	19a. Informant's Name/Relations		19b	. Mailin	g Address (Street a						, Zip Code)	
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Robert M. Brid	len/Husband	1:	2505	Knights	bridg	e Cou	ırt. Ro	ockv:	ille, 1	MD 20850	
ore	of Health of Health fitem 27 i		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation		20b. Place of	f Disno:	sition (Name of natory or other place Y	1	Janua'	te			or Town, State	
Ĕ	Pages ment of l ant: If its ury or o		'4 □Donation 5 □ Other (S	Specify)	Cremat	tori	um, Inc.		22, 2	005			, Maryland	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signatur ral Service	Elem	. M00803	Be Be	Name and Address thesda-C ethesda,	is of Facility hevy Mary1	Robe Chase and	rt A. Inc 20814-	Pump 7. -350	ohrey 1 557 Wi 1	Funeral Home sconsin Ave	
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	t only one cause on ea	sed the death. Do not line. neumonia	not ente	er the mode of dying	g, such as o	cardiac or	respiratory a	rest,		Approximate Interval Between Onset and Death 4 Days	
1	/Medical Examiner		resulting in death)	d	r as a consequence	of):							1 50 50	
Ł	Examiner	L	Sequentially list conditions,	U	reast Can								2 Years	
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 00 (0	r as a consequence	ot):								
_6	and and al-trar	хап	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):								
8760,	cate be executed physician and the burial-transit	dicai		d.										
9	tificat ig phy as thi	led									- 1			
Вох	death certifica e attending ph ed for use as t	hysician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Detail death	3[Ectopic pregnancy				2	23d. Date of d	•	
		sicia	in the past 12 months? 1 Yes 2 X No		nt at time of death		Other (specify)					Month	Day Year	
P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditi	ions contribution to des	th but not regulting in	n the ur	idorhina coure avic	on in Part I		23e Did to	abacco u	se contribute	to the cause of death?	
rds,	w requires ti been signe should be c	ed by	rattii. Ottor signineant conditi	ions continuating to dee				siiii raiti.			/es 2	_	Probably 4 Unknown	1
Record	aw 2 s b	ompieted								24a. Was		24b. Were	autopsy findings available completion of cause of	9
Ä	The age	Com								perfo	rmed? 2 X No	death	?	
Vital	Physicien: 1 this certifical ral director, p	Be (25. Was case referred to medical examiner?							Check only o	ne)			
of \	Physi this c al dire	ျ	1 ☐ Yes 2 💢 No		patient 2 ER/Ou	_						Other (Sp	pecify)	
n (ertification;	27. Manner of Death 1 Natural 5 □ Pendir	ing .		Time ol njury	28c. Injury Work	rat ⊲? Yes 2.∐N		d. Describe h	now injury	y occurred		
Division	en or:	lcat	3 ☐ Suicide 6 ☐ Could		f Injury - At home, fa	ırm stre		163 2		I. Location (5	Street and	d Number or i	Rural Route Number.	-
Ω	P S P C	ertii	4 Homicide determ		g, etc. (Specify)	, 50.	ot, tustory, omos			City or Tov				
	To the Hospitel of within 24 hours at To the Funerel Decompletely filled in	edical C		ing Physician: To the base and manner	sis of examination an									
	To the within 2 To the complet	Me	29b. Signature and title of certifie	er //-	4.11		29c. License	number			29d. Dat	e signed (Mo	nth, Day, Year)	
	/		Vosiph A	n. Hagger	y mis		D324	407			Janu	ary 19	, 2005	
1	19		30. Name and address of person Joseph M. Ha	who completed cause	of death (Item 23a)				ive	Rockwi				
Ì	Sta		31. Date liled (Month, Day, Year,) 32. Re	gistrar's Signature			L DL	-vc,	LOCKVI	- TTC	Halyl	20030	
	Registi	ar	JAN 2	4 2005	Colice of A.	_ /	inact!							

		•	For State Registrar	State of Ma	ıryland / [Depa <i>Cei</i>	artment of H	lealth ar Death	nd Men		giene Z	2005	01	512
	Physici		1. Decedent's Name (First, Middle, La	_{st)} John Benn	ett Br	obe	rg, Jr.			Date of Dea Month nuary	th	200 ^{Year}	3. Time of 8:30	
	/Medic Examin		4a. Facility Name (If not institution, giv Holy Cross Hospi				4b. City, Town, or Silver S				4c. Cou	unty of Death		
	Funeral Director		5. Social Security Number 6. S 360-20-3786	177 M OF F	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days			Date of Birth Month, Day Druary	8, 1929	9. Birthpl <i>Cou</i> n 1111	ace (State o try) nois	or Foreign
	Maryland s-f show	tor	10a. State 10b. County Maryland Montgom	ery	10c. City, Town							10	0d. Inside Ci	ity Limits
	th with the 23e or 28s	al Director	10e. Street and Number 13503 Dowlais Dr	ive			10f. Zip Code 208	353		1 _		of What Coun	-	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: it item 27 is marked other than "naturel; or items 23e or 28s-f show shi injury or other traumatic event. I'm Medical Exercit at mark to notified at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 □ Yes 2ሺ No	lispanic Origin an, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- in, etc.)		Race - Americ Black, White, o ecify: Whi	etc.	
Maryland 21215-0036	within 72 ho ene. than "natur the Medical	mpleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired tronics I	during most o			Natio:	of Business/Ind nal Ins	stítut	
land 2	uld be filed Aental Hygli rked other tic svent, I	To Be Co	17. Father's Name (First, Middle, Last, John Bennett B	roberg				18. Mother's	s Name (Fir					
	and 2 shoilealth and No. 27 is maler trauma		19a. Informant's Name/Relationship (Margaret J. Brobe	**			ng Address (Street Dowlais							
Baltimore,	Pages 1: ment of He ent: it iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemeter	ry, crer	sition <i>(Name of</i> natory or other place Crematorium		nuary 2005	23,		ion-CityorTo		nd
Balt	permit. Depart import eny inj		21. Signature of Funy al Service Ucer	ment		300	Name and Addre Dert A. Pum D West Mont	gomery A	Avenue,	, Rockv	ille, N	le, Inc. Maryland	20850–2	2805
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	the death. Do note. ic Card			ng, such as ca	ardiac or res	spiratory ar	rest,		Approximat Interval Bet Onset and	tween
H	/Medical Examiner	j.	Sequentially list conditions, if any, leading to immediate	_{b.} Cardia	c Arrhy	thm	ia							
8760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Eme, Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cerebr		ar	Accident							
.O. Box 68	The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy	′			23d.	Date of delive	*	Year
Δ.	w requires that been signed by should be deta	by	Part II. Other significant conditions of	contributing to death bu	ut not resulting i	n the u	nderlying cause giv	en in Part I.			es 2 N	contribute to the	37	death? Unknown
Il Records,		Completed								24a. Was autop	an 2 sy med? 2 No	24b. Were autoprior to condeath?	npletion of c	available ause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			t 3C DOA Oth	26. Place o						
ō		. To	1 ☐ Yes 2 X No 27. Manner of Death	1 X Inpatie		itpatier Time of	IL SELDOA	4 Nurs			ence 6 C	Other (Specify	1)	
ion	Attending Phy r death. ector: After thi by the funeral or the fune	atlon	1 Natural 5 Pending 2 Accident investigatio	(<i>Month, D</i> ay		njury	Wor	k? Yes 2□No		200011001		0001100		
Division	ital or Attenurs after deatl al Director: ed in by the	Certification;	3 Suicide 6 Could not be determined	building, etc	c. (Specify)		eet, factory, office			City or Tow	m, State)	lumber or Rura		nber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledical	one)	nysician: To the best of miner: On the basis of and manner sta	examination an	e, deatl nd/or in	vestigation, in my o	pinion, death	place, and occurred a	it the time,	date and pla	ace, and due to	the cause(s	5)
	11	W	29b. Signature and title of certifier	Alterain	g Phys	Lie	-1	61768				igned (Month, i		
J	203		30. Name and address of person who Fabienne Santel,	·			en Road,	Silve	r Spr	ing, l	Maryla	and 209	10	
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature		fortis							
			JAN 2	5 ZUUD A	The state of the s	-	-							

				pe or Print in Bla				-		gible.		
			1 - For State Registrar	State of Maryland	-	irtment of <i>tificate o</i> f		d Mental Hy	giene Reg. No.	005	0151	3
ï	DI		Decedent's Name (First, Middle, Last)					2. Date of De	ath	Vear	3. Time of Dea	th
	Physici /Medi		Josephine Ann Bro					Januar			10:00 PM	1 M
	Examir	ner	4a. Facility Name (If not institution, give st Stella Maris Hosp	ice		Luther			Ва	inty of Death	re	
	Funeral Director			7. Age (In yrs. las	Yrs.	If Under 1 Yea Months Day		lrs. 8. Date of Bir in. Month, Da May 2,	1919 1919	Cou	place (State or Foi intry) y Land	eign
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	1	Town or Loc			,			10d. Inside City Lin	
	with th	Dire	10e. Street and Number 2300 Dulaney Vall	ev Road		10f. Zip Code	1093		10g. Citizen		ntry?	
36	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-1 show early injury or other treumetic event. If a Mariell Examiner must be notified at Once.	Completed by Funeral Director	-	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1		Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.))- 14. F	SA Race - Ameri Black, White	, etc.	
21215-0036	within 72 hou ene. then "neture te Medical E	ompieted	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give I lite. E	ent's Usual Occ kind of work don OO NOT use retii	e during most of v red)	working	16b. Kind o	of Business/In	ndustry	unk
Maryland 2	uld be tiled Aental Hygie rked other tic event. II	To Be Co	17. Father's Name (First, Middle, Last) Joseph Rodge	rs		ICCI VICA	18. Mother's N	Nam <i>e (First, Middle</i> na Rodger:		name)		
lary	2 short and halfs ma	7 8	19a. Informant's Name/Relationship (Type Milton Brownstein/s					Rural Route Numb			c Code)	
ė,	1 and Health em 27		20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name of	1	Towson, I		286 on - City or T	own. State	
Baltimore,	Pages nent of int: If It iry or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☒ Donation 5 ☐ Other (Specify)	com	etery, cieп	natory or other p	ace)					
Balt	permit. Departr Importe eny inju		21. Signature of Sunetal Service Licenses	Pleasant	St Ba	Name and Add ate Ana ltimore	tomy Boa MD 21	rd 655 W. 201	Balti	more :	Street	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. cause on each line. DEMENTIA Due to (or as a consequent		er the mode of dy	ring, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death	1
68760,	rititicate be executed and physician and as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequer								
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			30. Name and address of person who com				mTMONT:	D4 100 01	/	1		
	ĕ Sta		DR. TARIO MARMOOD 31. Date filed (Month, Day, Year)	32. Segistrar's Signatur	ı VAL	LEY KD.	TIMONII	JM, MD 21	093			
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			_ FOI	partment of Health and Mertificate of Death		ene g. No.2 0 0 5	01514
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	OAIL.	4c. County of Death	
1	Examili	er	RUXTON OF PIKESVILLE	PIKESVILLE		BALTIMOR	E
	Funeral Director		5. Social Security Number 219-44-6326 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 90 Yrs	Months Days Hours Min	8. Date of Birth Month, Day, AUG. 8, 19	9. Birth Cou	place (State or Foreign ntry) MD
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	or 288	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	
	a 23a	ral	23 PINEWOOD FARMS COURT	21117		144 Barra America	USA
39	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantinat must be natified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. □ 1 Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
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ij	Pages ment of h tant; if ite jury or of		'4 Donation 5 Other (Specify) SHAAREI	ZION CEMETERY 01/		ROSEDALE	
Balt	permit, Pag Department Important; I any injury o once.	i b	21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOI 8900 REISTERSTOWN			
п			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical	4	resulting in death)	nation Preymonia			
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		Jer	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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Records,	law requas been 2 should	Completed by			24a. Was an autopsy	prior to co	opsy findings available
E B			Left Ventrulan Dysfusetion		perform 1 Yes 2	ed? death? No 1 ☐ Yes	2 🗆 No
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	pital ours el eral D		29a. Certifier Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and due to the car	uea/e) and manner as	etatad
	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of my knowledge, defining and manner stated.	r investigation, in my opinion, death occur	red at the time, dat	te and place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	
			* Kennet J Mick No	D23679		January 2	0,2005
1	2			-3 Tullamore Rd	Luther	ille MD :	21053
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			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
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	Examir	· · ·	4a. Facility Name (If not institution, § 2121 WINSOR GAR	,)		4b. City,	Town, or	Location of	of Death			unty of Death)
	Funeral Director		5. Social Security Number 212-28-8594 Usual Residence of Decedent	Sex 7. A	ge (In yrs. la:	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 11 30	31 Year)	9. Birth Coi	pplace (State or Foreign Intry) MD
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, Ite Modical Exactive must be notified at once.	Completed by Funeral Director	10a. State 10b. County MD N. 10e. Street and Number 2121 Windsor 11. Marital Status		Bal		10f. Zip	21	.207	gin? /Sa		U	of What Co	
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Maryland	uld be file Aental Hy rkad oth tic evant	To Be (17. Father's Name (First, Middle, La Andrey Carber								e (First, Middle, Brooks		патө)	
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Baltimore,	permit. Pag Department Important: any injury o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li	ecity)	Met	M. 22	2. Name an	d Addres	s of Facilit	¥t.	1/24/05 Balti			21215
-	Fnysician /Medical Examiner	her	23a. Ranf. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	line.	ence of):					or respiratory ar		ise.	Approximate Interval Between Onset and Death
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Division	al or Attendi s after death. Il Diractor: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of I	njury - At hon etc. (Specify)	ne, farm, st	reet, factory	, office			28f. Location (5 City or Tox		umber or Ru	ral Route Number,
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Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 5 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 18, 2005 5:25 P Carol Lee Chiarizia January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 120 Ridgepoint Place Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number Birthplace (Stete or Foreign Country) **Funeral** Days 1 ☐ M 2 🖼 F 217-68-7654 47 December 7, 1957 California Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 5 death with United States Items 23a 120 Ridgepoint Place 20878 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager 12 Mortgage Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Menta Jewell Outlaw Lerov Good 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Rebeccas Court, Smithburg, Maryland 21783 Thomas Chiarizia / Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If its any injury or oth once. January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc 2005 Bethesda, Maryland 21. Signature of Fureral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. Yngelote Barne M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Hypertensive Heart Disease 10 Years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Liver Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 \(\overline{\mathbb{N}} \) Residence 6 Other (Specify) 1XYes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification; Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide after within 24 hours a

To the Funeral L

completely filled Hed To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D041210 January 20, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, #501, Rockville, MD 20850 Barbara Bell, M.D. 31. Date filed (Markh Ray Year) 2005 State STORE D Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month Yee **Physician** Frank E. Cheatham 0202 AM 15 2005 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Healthcare
5. Social Sectify Number 6. Sex Baltmore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
June 29, 1927 Birthplace (State or Foreign Country) **Funeral** Days Hours 1MM 2□ F 214-22-6738 Yrs Director Georgia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Exactiver must be notified at MD Carrol1 Sykesville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5395 Viewpoint Court 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced 44-51 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygien 27 is marked other the treumatic event, E. technician electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank E. Cheatham Sr Dora Mae Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Healthcare 900 Caton Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or once. = 5 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pleasant 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 teusa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute MI disease or condition resulting in death) days /Medical Due to (or as a consequence of). Examiner IWREE Theumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760, by Physician/Medicai 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Year Day signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Covenary heart disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has b irector, page 2 s Diabetes autopsy performed? Myclodysplashe syndrome 1 ☐ Yes 200 1 ☐ Yes 2 ☐ No funeral director

of Vital Records, After Division death. after death Director: within 24 hours a
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25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 166997 January 15, 2005

State Registrar

the

in by

Deepak Baskaran 31. Date filed (Month, Day, Year) JAN 2 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ERT	L. DAY		For State	State	of Mary	land / Depa	artment rtificate			ind Me	ental Hy	1	1115	(11519
			Registrar 1. Decedent's Name (First, Mide	dle. Last)	_	061	inicate	OID	Calli		2. Date of De	Reg. No."		1 3	3. Time of Death
п	Physici			,	L.			Da	17		Month JAN.	19.	2005	.	10:10 A ^M
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	Funeral		5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last birthday)	If Under		If Under 2		8. Date of Bi	rth	9. Bi	irthplac	e (State or Foreign
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	ems er mu	Funeral Director	11. Marital Status	12. Was De Armed F	cedent Eve	r in U.S. 13.	Was Deced	ent of Hisp	panic Orig Mexican,	in? (Spec	cify Yes or No	o- 1	4. Race - Am Black, Whi		
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215	within 72 ene. then "ns he Medii	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Give	kind of wor DO NOT us	k done du e retired)	ring most	of workin	9				
21	giene giene er the	Completed by	12tH grade	na	-	MacH	ine						H Ste	eel	Corp
Maryland	tal Hyad oth	Be	17. Father's Name (First, Middle	, Last)							(First, Middle	, Maiden :	Sumame)		
7	hould d Mer marke marke	٦ ا	Willie Day 19a. Informant's Name/Relation	schin (Type Print)		10h Mailie	ag Addrass		Fanr			or City or	Town, State,	7in Co	odo l
Ma	nd 2 sho lith and 27 is ma	3	Robert Day										.C. SC		
ē,	s 1 ar		20a. Method of Disposition			20b. Place of Dispo	sition (Nam	e of	ī		ate		cation - City o		
E	Pages nent of I ant: If its ury or o		1			akwood	•		- 1	/26/	05	Ric	Hmond	1,	VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23a or 28a-f show amy injury or other freumatic event, the Medical Examinating must be retified at once.		21. Signature of Funeral Sërvic	e Licensee	Sme) <u>2</u>	arch	Address	of Facility	śt		imor	ce, Mo	3 :	21215
			23a. Part1. Enterthe disease, shock, or heart failure. Li	or complications that	caused the	- 17								_	pproximate terval Between
	Pnysician		Immediate Cause (Final disease or condition	A4	lieu	seleno	tie (Broke	UNC	see	lan	D	10011	Or	nset and Death
	/Medical		resulting in death)	a. Due to	o (or as a co	onsequence of):							C		
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8760,	cate be executed physician and the burial-transit	dlcal		d											
9	ortifica ing ph e as th	Φ :	IF FEMALE:												
Вох	death certific e attending p d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death 3	Ectopic pre					2	3d. Date of de Month	elivery Da	y Year
0	that the de led by the a detached f	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	nant at time nown	e or death 5	Other (spe	эспу)							•
Δ.	that ned by deta	by Ph	Part II. Other significant condi-	tions contributing to	death but n	ot resulting in the u	nderlying ca	use given	in Part I.		23e. Did 1	obacco us	se contribute t	to the c	ause of death?
rds	w requires that been signed b should be deta	ed b									1 🗆	Yes 2 ∑	2 √No 3□P	robably	y 4 ∐Unknown
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Vital	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medic examiner?	Hospital:						of Death	(Check only	one)			
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Division	Attendi er death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	mined 200. Flat	e of Injury	- At home, farm, str	eet, factory,	office		28			Number or R	Rural Ro	oute Number,
	tel or rs afte el Dir	Cert	4 [Nomicide	Dulli	ding, etc. (S	эр ө спу)				W	City or To	wn, State)			
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certify (Check only one) 2 Medics	ring Physician: To th at Examiner: On the and ma	ne best of m basis of exa nner stated.	amination and/or in	n occurred a vestigation,	it the time, in my opin	, date and nion, death	l place, ar h occurre	nd due to the d at the time,	cause(s) a date and	and manner a place, and du	s state	d. e cause(s)
	To the To the comp	Ž	29b. Signature and title of certif	er/ 1	11		29c.	License r					signed (Mon		
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1-	4		S.R.1	n who completed cau		111 PE	NN STE	REET,	BAL	TIMOE	RE, MAI	RYLAN	D 2120	1	
	Sta Registr		31. Date filed (Month, Day, Yea JAN 2 4	2005	Registrar's	Signature	de								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Angela DeTota /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Baltimore 7. Age (In yrs. last birthday)
O1 Yrs. Months Days Hours Min.

8. Date of Birth (Month, Day, Year)
OCTODER 26, 1913 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 214-34-4356 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I've Meulgal Examinar marke notified at 1 ☐ Yes 2 📉 No Baltimore Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7429 Harford Road 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Ciurca Sadie Agro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lois Rathmell/Daughter 17385 Deerfield Drive Prior Lake Minnesota 55372 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/05 Baltimore Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road B. Millon Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FRERRAL HEMORRHAGS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has filled in by the funeral director, page 2 autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After I Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner-stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

ORIGINAL

			1 - For State Registrar	State of Mar		artment o		nd Mental Hy	giene Reg. No. 2	A5 01521
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anna L.	Fink				2. Date of De Month Januar	Day	3. Ame of Death 799 3:15 a. M
	Examir		4a. Facility Name (If not institution, give				n, or Location of		4c. County of	
			Genesis Eldercar 5. Social Security Number 6. Sec		In yrs. last birthday)	If Under 1 Ye	Baltimor	e Pate of Bir	n/	
	Funeral Director		219-07-3100	M 2 X)F	94 Yrs.		ys Hours	Here B. Date of Bird Min. (Month, Date April Control of A	3, 1910	Birthplace (State or Foreign Country) Maryland
	e Maryland sa-f show	ctor	10a. State 10b. County Maryland n/a	1	oc.City, Town or Lo Baltin					10d. Inside City Limits 1 X Yes 2 □ No
	3a or 24	ai Dire	10e. Street and Number 3506 White Avenu	e		10f. Zip Coo	¹⁹ 2121	4	10g. Citizen of W	hat Country? d States
036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Itams 23a or 28a-f show umatic avent, I'm Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🂢 Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (in? (Specify Yes or No Puerto Rican, etc.)		- American Indian, K, White, etc. White
21215-0036	d within 72 ho piene. r than "natur the Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 yrs.	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Ockind of work do DO NOT use re Homemak	ne during most tired)	of working	16b. Kind of Bus	siness/Industry Home
Maryland	2 should ba filed withlr and Mental Hygiene. Is markad othar than sumatic avent, the M	To Be C	17. Father's Name (First, Middle, Last) Frederick Mert	-			Pau		<i>Maiden Sumame</i> ibling e r	ə)
	ind 2 sh alth and 27 Is m ar traum		19a. Informant's Name/Relationship (Ty. Mr. Ronald F. Holl				eet and Number Ce Avenu	or Rural Route Number	er, City or Town, S re, Mary	
altimore,	ages 1 a ant of He nt: If itam y or otha		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	lemoval from State	20b. Place of Dispo cemetery, crei	sition (Name o	place)	Date an. 21,2005	20c. Location - 0	City or Town, State
Baltii	permit. Pages 1 and 2 should by Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic a <u>once</u> .		21. Signature of Funeral Service License	Michael E.	-	2. Name and Ac	Idress of Facility		5305 Ha	arford Rd. ore,MD 21214
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition	ications that caused the cause on each line.	e death. Do not ent					Approximate Interval Between Onset and Death
/60,	/Medical Examiner hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	genenti	W J	trut	Disease		
O. Box 68	death certific e attending p d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregna			23d. Date Mont	of delivery th Day Year
О.	quires that in signad by ald be deta	by	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	nderlying cause	given in Part I.			bute to the cause of death?
Il Records,	The law requires that the sate has baen signad by the page 2 should be detached.	Completed							rmed? pr	ere autopsy findings available for to completion of cause of sath? Yes 2 \(\times \) No
VII	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	lospital:				of Death (Check only o		
Division of Vital	ding Phys h. After this o funeral dir	tion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. l	other: 4 → Nurs njury at Work?		lence 6 Other	
Divisi	after deat after deat Diractor: d in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)					r or Rural Route Number,
	To the Hospital or Attending Physician: which 24 hours after deals are this certifics. To the Funaral Director: After this certifics completely filled in by the funeral director, it	edical C	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of ner: On the basis of ex and manner stated	amination and/or in	n occurred at the vestigation, in m	e time, date and ny opinion, death	place, and due to the of occurred at the time, of	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier) r	ND	!	ense number		29d. Date signed	(Month, Day, Year)
i	2		30. Name and address of person who co	MASHMI!	821 N.	EUTAV		Snit 308,	BALTIM	2120 MI) 2120
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4	32. Register's						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Hobbs 1230 M 12, Solomon Jameir 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death facility Name (If not institution, give street and number) Examiner Maryland 5. Social Security Number Hospita Menera 7. Age (In yrs. Illst birthday) 8. Date of Birth (Month, Day, Year) 08 15 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**√** M 2□ F Days NY Months Hours Yrs 62 Director 42 074-56-1591 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examinar must be mutified at 1 Yes 2X No Gaithersburg Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 U.S.A. 10 West Brairstone Lane Items 23e Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married ŏ 1 ☐ Yes 2 ▼ No Specify: 2 Specify: 3 ☐ Widowed 4 X Divorced Black natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Various Jobs na Laborer 12th grade marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be 1 and 2 should be f Health and Mental I Solomon Hobbs Edith Hankins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 19a. Informant's Name/Relationship (Type, Print) 99 Health a 10 West Briarstone La, Gaithersburg, Taniqua Hobbs- Daughter Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ö 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page:
Department of
Importent: If i
any injury or one 5 Other (Specify) 4 Donation Metro Crematory Inc 1/22/05 Baltimore, Md Fig. ture Wuneral Service License March F/H West 23a. Part I. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tic /Medical as a consequence of): ImmunodeFiciency Virus **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and st the burial-transit The law requires that the death certificate be executed Sena to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 1 🗌 Yes 2 **1** No 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funeral I To the Hospitel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 12, 2005 CHOUDHRY MID

Registrar DHMH 17 Rev 1/2001

State

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

houdhry

32. Registrar's Signature

Shabbir

JAN 2 4 2005

31. Date filed (Month, Day, Year)

DR.

Maryl

		-	For Stete Registrar	State of Maryland / De	epartment of H			ene . No. 2005	01523
			Registrar Decedent's Name (First, Middle, Las				2. Date of Death		3. Time of Death
	Physicia	an	James E. Hawth				January	7, 2005	6:15 AM M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or	Location of Death	,	4c. County of Deat	
	Examin	ęr	Joseph Richey		Balt:	imore			
	Funeral Director		5. Social Security Number 6. Security Number 216–22–9779	ex 7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) July 29,	^(ear) 1928 Ma	hplace (State or Foreign untry) ryland
	P.		Usual Residence of Decedent	10c. City, Town o	or Longtion				10d. Inside City Limits
	arylar show	_	MD Howard		ott City				1 Yes 2 No
	89-f	Director		ELLIC	10f. Zip Code		100	. Citizen of What Co	
	with the		10e. Street and Number 9060 Town & Coun	try Blyd #A	2104	4.3	100		unuy:
	s 234	eral		-	13. Was Decedent of H		ecify Yes or No-	USA 14. Race - Ame	nican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural, or items 23e or 28e-f show enty injury or other treumetic event, I'm Marylad Examiner must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 127 Yes 2 No 51-52 If Yes, Give Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, Whit	
Ö	2 hou	ted	15. Decedent's Ed		ecedent's Usual Occup Give kind of work done		ing unk 16	b. Kind of Business/	Industry unk
Maryland 21215-0036	ithin 7	Completed	(Specify only highest gra	College (1-4or 5+)	ife. DO NOT use retired	d)	ang .		
2	ygien ygien yer th		12	1		10 Methodo Nom	e (First, Middle, Ma	iden Sumamal	
pu	be fill d off	Be	17. Father's Name (First, Middle, Last) James E. Hawtho						
2	d Mer narke	L _o	19a. Informant's Name/Relationship (Mailing Address (Street		melia Car	·	7in Cade)
Ma	d 2 sh h and 7 Is r treur	1	Gertrude Everely						
e,	1 and Healt em 2	1 3	20a. Method of Disposition	20b. Place of D	832 Robins Disposition (Name of	1		OWI	
Do	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State	crematory or other place	C O)			
Baltimore,	permit. P Departme Importen eny injur		21. Signature of Funeral Service Licer Arithony D	1598	22. Name and Addre		655 W. 1	Baltimore	Street
			23a. Part1. Enter the disease, or com	plications that caused the death. Do no					Approximate Interval Between
2	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):			1	
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Вох	ath ca	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of de Month	Day Year
0	the de y the a tched f	ysic	1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 Uner (specify)				
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Sor	> 0 0	ete					24a. Was an	24b. Were au	utopsy findings available
Rec	e lav has	Completed					autopsy performe	prior to death?	completion of cause of
	icien: Th certificate ector, pag	ပို	25. Was case referred to medical			26. Place of Dea	th (Check only one)	-	2 □ No
Vital	Physicien: this certific al director,	0	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA	or	ome 5 Residen		city) Hospice
of		II-	27. Manner of Death	28a. Date of Injury 28b. Tir		ry at	28d. Describe how		
lo	Attending P r death. sctor: After the tunera	atlo	1 Natural 5 Pending 2 Accident investigation	n		Yes 2 □ No			
Division	of or Attend after death Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined		m, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	itel or irs afte rel Din led in l								
	To the Hospitel or Attentwithin 24 hours after deall To the Funerel Director: completely filled in by the	edical	(Check only 2 Medicel Exam	nysicien: To the best of my knowledge, miner: On the basis of examination and and manner stated.	or investigation, in my	opinion, death occu	rred at the time, dat	e and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. Licens	se number	290	a. Date signed (Mont	n, Day, Tear)
•			2 Bom)	1 1/2	4110	-	immay 1	2005
_			30. Name and address of person who	completed cause of death (Item 23a) (The spirit of the completed cause of death (Item 23a) (The completed cause of deat	838 N.	Eutaw	St Bo	Mimore,	MD 21201
7.	St Regist	ate rar	31. Date filed (Month, Day, Year)	32/Figistrar's/Signature	Sparke				

JAMES HAWTHERNE

			State of Maryland / Department of He		•	ene	
			1 - For State Registrar Certificate of De			2005	01521
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Richard Clark Harrison		January	19, 2005	9:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death		4c. County of Dea	ath
			202012011 110071201	ethesda			tgomery
	Funeral		1 ☑ M 2 ☐ F Yrs Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		447-36-2428 65 Tis. Usual Residence of Decedent		May 9,	1939	0klahoma
	yland		10a. State 10b. County 10c. City, Town or Location			·	10d. Inside City Limits
	B Mar	ctor	Maryland Montgomery Roo	ckville			1 ☐ Yes 2 🙀 No
	ith th	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23e			20855	-#. V N-	Unite	d States
	Itam Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	Mexican, Puerto F	Rican, etc.)	Black, Whi	
99	ursal	Ď	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1961 –1963	Specify:		Specify:	ican Indian
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f ehow he Modical Examinations by Locified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done dur	on ring most of workin	ig	6b. Kind of Business	*
7	Mithin ne.	d m	Elementary/Secondary (0-12) College (1-4or 5+)				nstitutes of
i B	be filed v ntal Hygie sd othar t		1 Contract Rev:	8. Mother's Name		Hea aiden Sumame)	TEU
au	d be Bntal kad o	To Be	Ben Harrison	Ţ	Wilma Cr	ow Walkab	Out
ary	2 should be and Mental le markad craumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and				
	and 2 salth a n 27 le		Joan Harrison/ Wife 2 Indian Hills	s Court 1	Rockvill	e, Maryla	nd 20855
ore	es 1 and 2 of Health if item 27 or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20b. Place of Disposition (Name of cemetary, crematory or other place) ParkLawn Memoria.			Oc. Location - City of	r Town, State
Ĕ	Pages Iment of I tant: If its jury or o		`4 □Donation 5 □ Other (Specify) Park	1 440 4	2005	Rockville	,Maryland
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le markad other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Modical Examinational be notified at once.		21. Signature of Fineral Service Licensee 22. Name and Address Bethesda-Che Bethesda, Ma	of Facility RODG evy Chase aryland	ert A. P e. Inc. 20814-35	umphrey F 7557 Wisc 01	uneral Home/ onsin Avenue
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure				Immediate
	/Medical Examiner		Due to (or as a consequence of):				0.36 1.1
		e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				2 Months
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events c.				
Ö,	te be executed ysician and e burial-transit	Exc	resulting in death) Last Due to (or as a consequence of):				
8760,		dical	d				
× 68	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	alivear
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No			Month	Day Year
o.	t the c by the achec	hysi	9 Unknown				
S,	res tha signed I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.			to the cause of death?
ord	w require been sign	ted	Renal Failure		1 🗆 Yes	s 2 <u>X</u> No 3 □ P	robably 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed	Lymphadenopathy		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
a H	ician: The lav certificate has rector, page 2				1 ☐ Yes 2	No 1□Ye	s 2 No
Ξ	Physician: this certificatal director, i	Be c	avaminar?	26. Place of Death) nce 6 □Other (Spe	:6.0
of	nding Physician: th. : After this certifica s funeral director, p	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury a		8d. Describe hov		ecity)
<u>o</u>	Attending r death. ector: After by the funer	atlo	2 Accident investigation M 1 TYe	s 2 No			
Division	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
Q	oital o urs aft rral Di		76				
	Hosp 24 hor Fune stely fi	edical	29a. Certifier (Check only one) 1	, date and place, a nion, death occurre	and due to the cau ad at the time, dat	use(s) and manner a te and place, and du	is stated. e to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier 29c. License n	number	29	d. Date signed (Mon	oth, Day, Year)
•	- > - 0		I have that I looken me 121	435	J	muan 19	2005
	1011		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. //	2 /	1011	20002
	1		21 Data filed (March Pay Car) 23 Projector's Singular	7ily	willy in	1, INA	10906
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 4 2005 32 Registrar's Signature		, ,	•	
		3 4	JAN 6 2 LOOJ				

			For State Registrar	'State' of Maryland / Depa Cer	anment of Health and I rtificate of Death	/lental Hyglei Reg.t	000
			Negistrar Necedent's Name (First, Middle, Last)			2. Date of Death	3. Tinle of Death
	Physicia /Medic	al	Franklin	William	Knox	JANHARY	14,2005 4 20 PM
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death Baltimore		4c. County of Death
			Union Memorial 5. Social Security Number 6. Sec		If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
п	Funeral Director		214-20-9240	M 2□F 77 Yrs.	Months Days Hours Min.	o1 27	ar) Country) 27 MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryla	ō	MD NA	Baltimor	:e		X Yes 2 No
	n the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	23a c		4118 Elderon Ave)	21215		U.S.A. 14. Race - American Indian,
	72 hours after death with the Maryland naturel: or Items 23a or 28e-f show disat Examiner must be notified at	Funeral	11. Marital Status Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
920	urs aft	þ	3 Widowed 4 Divorced	1 ☐ Yes XIXNo If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: Black
5-0036	72 ho natur dical	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Dece e completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b	. Kind of Business/Industry
2121	within ene. than "	ldui	Elementary/Secondary (0-12) 7th grade	College (1-4or 5+)	nitation Worke	r B	altimore City
d 2	filed withi Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)	na sa		ne (First, Middle, Maid	
/lan	iould be i Mental narked o	To B	William Knox			ae Jones	
Maryland			19a. Informant's Name/Relationship (T)		ng Address (Street and Number or Ru		
	1 and 2 sl Heelth and 10 sl tem 27 is nother treur		Aubrey Knox-Neg 20a. Method of Disposition		Elderon Ave, In the second section (Name of matory or other place)		e Md 21215 c. Location - City or Town, State
JO.			1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Crematory Inc.	1/22/05	Baltimore, Md
Baltimore,	permit. Pages 1 as Depertment of Hee Importent: If Item eny injury or othe once.		21. Signature of Funeral Service Licens	99 2	2. Name and Address of Facility arch F/H West		
ä	88E 8	45 - 3	Typett	1 h. Ames 4	300 Wabash Ave.	Baltimo	ore, Md 21215
				lications that caused the death. Do not en ne cause on each line.		or respiratory arrest,	
	Pnysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	aPNEUMO/ Due to (or as a consequence of):	VIA		IWEEK
-	Examiner			Due to (or as a consequence or).			
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			
68760,	icate be executed physicien and s the burial-transit			d			
	tificate ig phys as the	ledical		0.			
Box	eath certifi attending I I for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year
6 .	the at	ysici	1 Yes 2 No	4 Pregnant at time of death 5 9 Unknown	Other (specify)		
P.O.	The law requires that the death te has been signed by the atter age 2 should be detached for u			ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rds	w requires been sign should be	ed by				1 🗆 Yes	2 No 3 Probably 4 Whitehown
of Vital Records,	law requas been 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
=		Соп				performed 1 ☐ Yes 2 😾	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 Legatient 2 ER/Outpatie	Other	ath (Check only one)	ee 6 ☐Other (Specify)
	g Physier this	7: To	1 Yes 2 No	28a. Date of Injury 28b. Time	All the state of t	28d. Describe how	
ion	E 28 5	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation		M 1 Yes 2 No		
Division	- 9	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
0	Hospitel of the hours of Funeral Distriction (ell) filled is		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, dea	th occurred at the time, date and place	a, and due to the caus	se(s) and manner as stated.
	To the Hospitel or within 24 hours eff To the Funeral D completely filled in	edical	(Check only 2 Medical Examone)	iner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occi	urred at the time, date	and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	:42	29c. License number	29d.	Date signed (Month, Day, Year)
	h		Millenn	name MD	D41123	V	WUARY 17,000
1	3			completed cause of death (Item 23a) (Type	O, Print) YON MEMORIAL	HUSP 201	EUNIV PKWY
1	St	ate	31. Date filed (Month, Day, Year) 200	Registrar's Signature	acti	100	Date signed (Month, Day, Year) NUARY 14, 2005 EUNIV PKWY LTIMORE MODIAL
	Poniet		IAN L 4 LUU	7 Marshard			

			State of Man				lental Hy	giene	
			State Registrar	Cei	rtificate of I	Death		Reg. No.	5 01526
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day Ye	3. Time of Death
	/Medic	al	Ellen M. Lepper 4a. Facility Name (If not institution, give street and number)		4h City Town or	r Location of Death	January	4c. County of I	
	Examin	er	12227 Tildenwood Drive						
	Funeral			In yrs. last birthday)		If Under 24 Hrs.	8. Date of Bir	th 9	gomery Birthplace (State or Foreign
Н	Director		156-40-3283 1□M 2反F	56 Yrs.	Months Days	Hours Min.	(Month, Da March 2		Country) ennsylvania
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	antine .				10d. Inside City Limits
	shov	'n		•					1 ☑ Yes 2 ☐ No
	the A	ect	Maryland Montgomery 10e. Street and Number	Rockvill	.e 10f. Zip Code			10g. Citizen of Wha	t Country?
	With Se or	Di	12227 Tildenwood Drive		20852	2		United St	-
	death ms 2;	Funeral Director	11. Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H				American Indian,
ထ္	after or ite	Fu	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☐ Never Married 2 ☑ Married I ☐ Yes, 2 ☑ No If Yes, Give		rr Yes, speciny Cuba 1 □ Yes 2 ☑ No	Specify:	Hican, etc.)		White, etc. White
93	ours ral',	d by	3 Widowed 4 Divorced Year or Dates:						
2	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Busin	•
2	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		er/Owner	4/		Commun	ications
0	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked othar than "natural", or items 23e or 28a-f show umatic avant, The Medical Exameration to redified at	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	- <u>y</u>
<u>a</u>	lid be fental rked	To B	William A. Meeley, Sr.			Mary E	llen Mc	Elwee	
Maryland 21215-0036	shous and M		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			er, City or Town, Sta	te, Zip Code)
Σ.	and 2 ealth n 27 i		Brian C. Meeley/Brother						rginia 22192
ore	ges 1 t of H If itan		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other plac	Jan	Date uary	20c. Location - City	y or Town, State
Baltimore,	tment: tant:			Montgomery		and the second second second	2005	Bethesda,	Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23e or 28a-f show any injury or other traumatic avant, the Medical Exament and must be redified at once.		21. Signature of Funeral Service Licensee MO 1 42	20 Ro	Name and Address bert A. Pur	ss of Facility Mphrey Fune	ral Home,	Rockville, ville, Mary	Inc.
			23a. Part1. Enter the disease, or complications that caused the						Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final						Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Metastat Due to (or as a c	tic Lung (Cancer				6 months
	Examiner		Sequentially list conditions						
	ם פ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	опевушенев отде					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a c	onsequence of):					
8760,	ate be executed thysician and the burial-transit		255 15 (5) 43 2 5	anaoquanio oij,					
687	ficate p phys is the	edical	d						
Вох	death certific e attending pl od for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of		7 5 -4			23d. Date of	delivery
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	at the de by the a stached i	hys	9 Unknown			·	24		
	The law requires that the ale has been signed by the page 2 should be detache	by	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.			te to the cause of death?
Records,	w requir been si should	Completed	V				1		Probably 4 Unknown
3ec	e law has t	шb					24a. Was autop		e autopsy findings available to completion of cause of h?
a		e Co	25. Was case referred to medical				1 🗌 Yes	2 X No 1 □	
Vital	ysician: The is certificate hadirector, page	To Be	examiner? 1 □ Yes 2 🎛 No Hospital: 1 □ Inpatient	2 ER/Outpatien	at 3 DOA Oth	er: 4 Nursing H		dence 6 Other (Specifu)
٥	# # E	n: T	27. Manner of Death 28a. Date of Injury	28b. Time of				now injury occurred	opouny)
jo	anding fath. or: After he funer	atlo	2 Accident Investigation	ous, rigary		Yes 2 □ No			
Division of		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (At home, farm, str Specify) 	reet, factory, office		28f. Location (S City or Tov		r Rural Route Number,
	a Hospital or Attand 24 hours after death a Funaral Director: etely filled in by the		29a. Certifier 1 X Certifying Physician: To the best of n			<u> </u>			
	To tha Hospital or within 24 hours afte To tha Funaral Dii completely filled in	edical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of n and manner stated	camination and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and place, and	due to the cause(s)
	To tha within 2 To tha Complet	Me	29b. Signature and title of codifier	/	29c. License	e number		29d. Date signed (N	fonth, Day, Year)
)) //_ / #/-		D00	033293		January	17, 2005
	20		30. Name and address of person who completed cause of deat						
	Sta	to	Frederick Smith, M.D., 5454 W 31. Date filed (Month, Day, Year) 32. Regstrar's	<u>isconsin</u>	Avenue #1	300, Chev	y Chase,	Maryland	20815
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's JAN 2 4 2005	as M. A.	world				

003	75		State of Maryland / Department of Health and N	nental Hyg	giene	group
		·	1 - State Registrar Certificate of Death	1	Reg. No. LUU	5 0 1 5 2 7
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic Examin		RICCO MCKINNEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	⊥ Januar	y 15, 200 4c. County of 0	
4	Lxaiiii		University HospitalShock Trauma Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, Day	, rear)	Birthplace (State or Foreign Country)
	Director		217 -88 - 15 96 XM 2 Z Z Yrs. Usual Residence of Decedent	Sept. 22	1975	Maryland
	ryland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Ma 8a-1 s	ecto	MD NA Baitimore City			1 Yes 2 □ No
	with the	Dir	10e. Street and Number 10f. Zip Code 10f. Zip Code 21216		10g. Citizen of Wha	A
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?)	pecify Yes or No-		American Indian,
36	or Ite	by Fu	1 Never Married 2 Married 1 Yes 2 No Specify:	Triodii, etc.)	Specify:	White, etc.
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Medical Exama har must be notified at	ed p	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usuat Occupation		16b. Kind of Busin	
215	hin 72 9. Bn "na Medis	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	king		,
2121	ed wit ygien ygien yertha	Con	11 Laborer		Work	nouse
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, I're Medical Examinational be notified at	Be c		- American Control	Maiden Sumame) et Bro	(17)
aryl	shoute nd Me mark mark	င္	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur			
	1 and 2 Health a tem 27 is		Murrel Mckinney 4530 FAIR FAX R	d Bai	timere 1	ND 21216
ore	tges 1 and of He	13	1 Rurial 2 Cremation 3 Removal from State cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
3altimore,	t. Partimer rtant rtant		4 □ Donation 5 □ Other (Specify) Bay View Cremating 1-2			450
Ba	Depar Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Fichity Runcild A Hauper 108 West M	your fe	ineral &	me
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		tmmediate Cause (Final disease or condition) We take a way of the condition of the conditi	due	la	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of)			
	BRU	er	Sequentially list conditions, b. Due to (or as a consequence or):			
	cuted	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
,092	ate be executed nysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):			
æ	- W	Physiclan/Medical	d.			
Вох 6	Attending Physician: The law requires that the death certifical r death. craceath. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
	that the death cer ed by the attendir detached for use	sicla	in the past 12 months? 1 Yes 2 No 1 Helpropur		Month	Day Year
P.O.	d by the	Phy	9 Unknown. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did to	hacco uso contribu	te to the cause of death?
ds,	signed be del	d by	Part II. Other significant conditions contributing to death but not resulting in the differing cause given in Part I.	1 🗆 Y		Probably 4 Unknown
cor	w requires been sign should be	Completed		24a. Was :	an 24b. Wer	e autopsy findings available
Re	The lav	omb		autop perfor	sy prior	to completion of cause of h? Yes 2□ No
/ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			
of	Physic this c	1.			ence 6 Other (Specify)
on	th. : After s funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 S - 05 28b. Time of Injury Work? 27:71 PM 28c. Injury at Work? 1 Yes 2 No	Deroa	sed S	hot
Division of Vital Records,	Attendi er death. ector: A by the fo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S	itreet and Number of	Rural Route Number,
Ö	ital or Ins afte ral Dii		stillet			Balto MD
	Hosp 24 house Fune etely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and the of certifier 29c. License number		29d. Date signed (N	fonth, Day, Year)
			DOME OCME		January 16	5, 2005
/	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street B	altimax	Mass7	- J 01001
1	Sta		31. Date filed (Month, Day, Year) 32. Registrate Signature	arr THIOLE	, rarytai	IG ZIZUI
	Regist	rar	JAN 2 4 2005 January J. January J.			

		1	For State	State of	Maryland		artment <i>rtificate</i>					ene ₂ (005	01528
			Registrar 1. Decedent's Name (First, Middle, I	.ast)							Date of Death	1	V	3. Time of Death
	Physicia	ın	Maude Evely								Month January	Day 23,	2005	2:00 p M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and nun	nber)		4b. City, T	own, or	Location of	of Death		4c. Cou	nty of Death	
	LXamin		Lorien Nursing	Home			T	ane	ytown	L			Carro	
	Funeral Director		5. Social Security Number 6 216–12–6279	Sex 1 □ M 2½√ F	7. Age (<i>In yr</i> s. <i>I</i>	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	Date of Birth (Month, Day, Sep 26,	^{Year)} 1913	9. Birth Cou Mai	place (State or Foreign ntry) Cyland
	D .	-	Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation							10d. Inside City Limits
	shov			-011		,,		We	estmi	nster				1 ☐ Yes 2 🙀 No
	the N	ect	Maryland Carr 10e. Street and Number	.OTT			10f. Zip (Code			10	Og. Citizen	of What Cou	intry?
	With Se or	٥	102 Timberridge	Road ap	t 309			2]	L157				USA	
	death ms 23	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Decede	ent of Hi	spanic Ori	igin? (Speci	fy Yes or No- can, etc.)		Race - Amer Black, White	
o.	or Ite	Ē	1 Never Married 2 Married	Armed Fo	2 🔀 No		1 ☐ Yes 2		Specify:		,,			white
5	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show odical Experient neat be notified at	d by	3 MWidowed 4 ☐ Divorced	If Yes, Giv Year or D	ates:						1		f Business/li	
2-	72 h "natu	ete	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual kind of work DO NOT use	k done d	turing mos	st of working		16b. Kina o	i business/ii	nuustry
21215-0036	filed within 72 Hygiene. other than "nal snt, Ite Medic	Completed	Elementary/Secondary (0-12)	College (1	I-4or 5+)		Homem		•			Ow	n Home	е
	filed withi Hygiene. other than ent, I.e.M	ပိ	17. Father's Name (First, Middle, La	st)					18. Moth	er's Name (First, Middle, M	Maiden Sun	rame)	
au	ould be Mental arked o	To Be	William Gemil	L Matthew	<i>I</i> S				M	laude 1	Evelyn	Batch	elor	
Maryland	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship								Route Number,			ip Code)
	1 and 2 Health Iem 27 I	1 8	Susan J. Batema	an, daugh		270 Place of Dispo			eek R	ld, Pa	sadena,		LLZZ on - City or 1	Town State
ore	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 分 Cremation 3	☐Removal from	State	emetery, cre	matory or ot	her plac		01/26			-	
Baltimore,	permit. Pag Department Importent: any injury c		*4 □ Donation 5 □ Other (Special Service Li	icity)	400723	arroll	Crema 2. Name and				line Fu		npstea	
Bal	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natur any injury or other treumatic event, It a Modical Once.		21. Signature of Furtheral Service Ci	7/	10,23	0					Hampst			
			23a. Part1. Enter the disease, or c	omplications that of	caused the deat	h. Do not en								Approximate Interval Between
	Pnysician	1	shock, or heart failure. List of Immediate Cause (Final	ny one cause on e	each line.	n		1	1	inl	A			Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	(or as a conseq	uence (n)	ran,	er.			non a			- Carro
П	Examiner		Sequentially list conditions	b. ar	terro	sil	with	ار	/noe	enla	dise	euse		25yr
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	(Jence of):								•
	and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	quence of):								
760,	ate be executed hysician and the burial-transit	calE												
687	ficate pphysis the			G										
Вох	death certifica e attending ph d for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn.		□Ectopic pr	eonancy	,			23d.	Date of deli	ivery Day Year
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ NO		nant at time of o		Other (sp						MOHIII	Day 16at
P.0	at the I by the	Phys	9 ☐ Unknown Part II. Other significant condition		laath but aat ro	suffice in the	undorhina e	auce an	on in Part	1	23e. Did to	bacco use	contribute to	the cause of death?
Ś	Se UE	by	Part II, Other significant condition	is continuing to c	ieatii but iiot ies	saking in the	undanying o	aaso gii			1 🗆 Y	es 2 🕮 H	of 3□Pro	obably 4 Unknown
Record	w require been sign	Completed									24a. Was a	ın 2	4b. Were au	topsy findings available
Zec	e la has je 2	I du									autops	sy med?	death?	completion of cause of
a		e Co	25. Was case referred to medical						26. Plac	e of Death	1 ☐ Yes (Check only or	2 1 No	1 🗀 1 83	20.110
Vital		O B	examiner? 1 Yes 2 70	Hospital:	Inpatient 2] ER/Outpatie	ent 3 DC	Ot Ott			e 5 Resid		Other (Spec	city)
o t		T:u	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time Injury	of 2	8c. Injui	ry at rk?	2	8d. Describe h	ow injury o	curred	
ior	Attending in death.	atlo	2 Accident investig	ation			М		Yes 2		0/ // /0			and Double Marchae
Division	2 th 12 c	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 286 Plac	e of Injury - At hat ding, etc. (Speci		treet, factory	y, office		2	City or Tow	n, State)	umber or Hi	ıral Route Number,
	pitel o		202 Cartifier 1 Partituin	Physician: To th	e best of my kn	owledne des	ith occurred	at the ti	me, date a	and place, a	nd due to the o	ause(s) and	d manner as	stated.
	To the Hospitel c within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Sertifying (Check only 2 Medical E	xaminer: On the	basis of examin nner stated.	ation and/or i	nvestigation	, in my	opinion, de	eath occurre	d at the time, o	date and pla	ice, and due	to the cause(s)
	ro the within 2 To the comple	Me	29b. Signature and title of certifier	1.			290	c. Licens	se number	7	- 4	29d. Date si	igned (Mont	h, Day, Year)
)	, ,,,		b (bulm h)	Mucho	Witm	MD	1)2	544	13		1/2	3/2	005
	1,		30. Name and address of person v	vho completed cau	use of death (Ite	m 23a) (Type	e, Print)	`	,					lend 21157
	~		John wm	ddle	Registrar's Sign	S Poo,	le /Y	oa	ch li	Vesto	ninst	1 20	Mary	1 Kind NIS7
	St Regist	ate	31. Date filed (Month, Day, Year)	2005	egistrar s Sign	K A	hard.							
		12.51	■ UINI ~ ±	LUUJ A	Carried St. Hallman	NJ" 44	Carried Street							

DHMH 17 Rev 1/2001

ORIGINAL

		1 . s	or Itate Registrar		State of Ma	ryland /		rtment of		Mental Hy	/giene	71111	5	01529
Phys	iciar	1. De	cedent's Name (F	irst, Middle, Last		11				2. Date of Do			ar	3. Time of Death 5:52a _M
/Me	dica	4. 5			street and number)			4b. City, Town	, or Location of Dea			. County of D		
Exan	IIIIe		Oak Cre		llage			_	timore			altim		
Funer Directo		21	6 – 10 – 15	26 10	x 7. Age	88	birthday) Yrs.	If Under 1 Yes Months Day			rth ay, Year)	9.1	Birthpla Country	ce (State or Foreign
Maryland f ehow	į	10a. S		cedent b.County Baltim	ore	10c. City, T	own or Loc		ltimore				100	d. Inside City Limits 1 Yes 2 □ No
th the or 28a-	Director	10e. S	Street and Numbe	r				10f. Zip Code	9		10g. Cit	izen of What	Countr	y?
ath wil				th Cli	nton Str				205			SA		
2 12 15-UU36 d within 72 hours after death with the Maryland jiens, rither, retries 23a or 28a-f ehow the Modeleal Extratiner resulting and	hy Europe	3	arital Status □ Never Married ☑ Widowed 4 □	_	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 N If Yes, Give Year or Dates:			Vas Decedent of Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue No <i>Specify:</i>	(Specify Yes or Ni arto Rican, etc.)	0-	14. Race - A Black, W Specify: W	/hite, et	c.
Z I 3-UU36 thin 72 hours af e. Audical Extent	0			Decedent's Edu		1	6a. Deced	ent's Usual Occ kind of work do	cupation ne during most of w ired)	orking		ind of Busine		,
within 72 iene. Than "na	potoleano	Ele	mentary/Seconda	ry (0-12)	College (1-4or 5	+) 5		stress	irea)		Kr	ramer	Co	mpany
e file	D C C		ather's Name (Firs	t, Middle, Last)		1			18. Mother's N	ame (First, Middle	, Maiden	Sumame)		
aryiand should be fit and Mental Hy marked oth	F	2 0	George							erine S				
Mar Mar Mand Ith and 27 is m	1		Informant's Name Danne B						et and Number or I Head Roa					
the the		20a. I	Method of Disposi	tion		20b. Place	e of Dispos	sition (Name of		Date	_	ocation - City		
Page Trent ant: if			X Burial 2 C Donation 5		Removal from State	Sacı		eartof		/26/05	Bal	ltimo	re	MD
Dall permit. Depertr Importa any inji	Suce.	21. S	ignature of Funer	LService Licens	600	01	22	. Name and Add	dress of Facility	Connell	yFur	neralH	Home	eofEssex
		239	Part1 Enter the d	lisease or comp	lications that caused ne cause on each lin	the death	Ownot ente	300 I	Mace Ave	Balt	imor	e MD	1 4	221 Approximate nterval Between
Physicia (ate be executed bhysician and bhysician and the burial-transit	al er	Seque of any cause Cause that i result	adiate Cause (Finise or condition ting in death) entially list condition, leading to imme e. Enter Underlying (Disease or injunitiated events ting in death) Last	ions, diate		Diabeanon a	240 CB OI):		ar Disa	ous e			W.	Onset and Death
the death certiff ty the attending y the attending	lealpow/weiglando		MALE: Was decedent prein the past 12 mo 1 Yes 2 No 9 Unknown	mths?	d	2 Fetal de	ath 3	Ectopic pregna				23d. Date of Month		/ Day Year
S, T as that gned b	0 74	Part I	I. Other significa	nt conditions co	ntributing to death bu	ut not resultir	ng in the ur	nderlying cause	given in Part I.					cause of death?
cord w require been six											Yes 2] Probat	
	Total caro									1 🗆 Yes	ormed? 2 No	prior	to comp	sy findings available pletion of cause of
Of VITAL Physicien: T this certificat ral director, pa	0	9	Vas case referred xaminer?		Hospital:	nt 2□ER	/Qutpatien	t 3 DOA	O#	eath (Check only Home 5 Res		6 □Other (S	Snecify)	
	III H		lanner of Death	□ Pending investigation	28a. Date of Injur (Month, Day	y 28	b. Time of Injury	28c. lr	ojury at Vork? Yes 2 No	28d. Describe			poony	
DIVISION C To the Hospitel or Attending P within 24 hours effer death. To the Funerel Director: Affer it completely filled in by the funera	Coreificaelian	3 4	Suicide 6	Could not be determined	28e. Place of Injubulding, etc	ury - At home c. (Specify)	, farm, stre	eet, factory, office	ce	28f. Location City or To			r Rural I	Route Number,
Hospi 24 hou Funer stely fill	100	29a.			rsician: To the best of iner: On the basis of and manner sta	examination								
To the within To the Comple			Signature and title	of certifier	and manner sta			29c. Lice	ense number		29d. Da	te signed (Mi	onth, Da	ay, Year)
\		30 N	lame and address	of person who c	ompleted cause of d	eath (Item 23	Ba) (Type,	-	8646		Jav	racy	2	4 2005
1		An			1800 wal	ther	Boule		Parkville	WO 3.	123	4		
Regi	State stra	-	ate filed (Month, i	JAN 2.4	32. Registra	ar's Signature								
DHMH 17 Rev	1/200	1		VIII W T	£003	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	RIGINA	Sporte					i	
						O1		1 1000						

				partment of Health and Me ertificate of Death	ental Hygier Reg. I	/1115	01530
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	/Medic	al	Alvin H. Miles, JR 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2005 4c. County of Death	6:35 P M
	Examin	er	Washington Adventist Hospital	Takoma Park		lontgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth	9 Birth	place (State or Foreign
	Director		214-58-4179	C	(Month, Day, Yea)7/26/195	2 Mary	land
	yland how		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	se May	ctor	Maryland Prince Georges Beltsvil				X Yes 2 No
	with the or 2	Dire	10e. Street and Number	10f. Zip Code 20705		Citizen of What Cou	intry?
	death ms 23	nera	4509 Romlon Street Apt 204 11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Speci	USA fy Yes or No-	14. Race - Ameri	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married TayYes 2 ☐ No If Yes, Give	If Yes, specify Cuban, Mexican, Puèrto Ri 1 ☐ Yes 2 ☐XNo Specify:	can, etc.)	Black, White	
00	hours stural'		3 ☐ Widowed 4 ☑ Divorced Year or Dates: 170-174	cedent's Usual Occupation	16b.	Specify: Whit	
215	thin 72 e. en "na Medir	Completed	(Specify only highest grade completed) (G.	ve kind of work done during most of working . DO NOT use retired)	7	emens Bui	•
7	led wil lygien her th		2 Elec	tronics Technician		chnologie	s
Maryland 21215-0036	d be fi	To Be	17. Father's Name (First, Middle, Last) Alvin H. Miles, SR.	18. Mother's Name (A		en Sumame)	
ary	and Me	F		iling Address (Street and Number or Rural F		y or Town, State, Zi	p Code)
Σ,	and 2 ealth a m 27 is			5 Bonaventure Drive			
Baltimore,	iges 1 of of H if itel		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mary 1	position (Name of Paramatory or other place)	200.	Location - City or T	
Ē	artmer ortant injury		`4 □Donation 5 □Other (Specify) Veterans 21. Signature of Fuperal Service Licensee	Cemetery 01/27/ 22. Name and Address of Facility Robe	2005 Cro	wnsville, ans Funer	MD al Home
Ã	permi Depar Impor any ir		1	6000 Annapolis Road			
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Liver Cirrhosis				
	Examiner		Due to (or as a consequence of): Hepatic Failure				
	P #	Iner	if any, leading to immediate cause. Enter Underlying				
	and I-trans	Examiner	Cause (Disease or injury that initiated events c:				
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical E	d				
9	ntificati ng phy as the	Medic	IF FEMALE:				
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death	B Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
O.		yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)			
S, D		by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	the cause of death?
ord	w requires been sign should be				1 🗆 Yes	2□No 3□Pro	bably 4X Unknown
Vital Record	e law has b	Completed			24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
tal	ician: The l certificate ha rector, page	a	25. Was case referred to medical	26. Place of Death (1 ☐ Yes 21☐1	No 1 ☐ Yes	2X No
of Vi	d s	To B	examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 X ER/Outpat	Othon		6 ☐Other (Speci	fy)
o u			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	/ Work?	d. Describe how in	jury occurred	
Division	II or Attendi after death. I Director: A d in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No street, factory, office 28	f. Location (Street	and Number or Run	al Route Number,
Ö	s after s after al Dire	Certification:	4 ☐ Homicide Getermined building, etc. (Specify)		City or Town, Sta	ate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only (Ch	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	o the ithin 2 o the omplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month,	Day, Year)
	⊢ s ⊢ ō		· Negusail	D4547	1	122105	
	10%)		30. Name and address of person who completed cause of death (Item 23a) (Typ		0 Carrol	l Avenue	
			Yeheyis Neguesie, M.D. Washington A	dventist Hospital T	akoma Pai	rk, MD 209	912
	Sta Registr	- 1	31. Date filed (Month, Day Year) 4 2005 32. Registrar's Signature	Sperte			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 17, 8:33 Рм Louis Kenton Meals 2005 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or For Country) | Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Yrs. 205-07-0154 85 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event. The Medical Examples must be notified at 1 ☐ Yas 2 🛣 No Director Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15701 Jones Lane 20878 United States death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural, or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Decupation 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Mathematician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) G. Kenton Meals Blanche Waggoner ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other traum once. Gladys S. Meals / Wife 15701 Jones Lane, Darnestown, Maryland 20878 January 25, Gettysburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 2005 ⁵ 4 □ Donation 5 □ Other (Specify) Pennsylvanía 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Ungelett Browns 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician m 40 Cartial 70U-5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Schrodic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the t use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🕅 No 3 🗀 Probably 4 🗀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? res 2 \(\Omega\) No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Ē 2 1 ☐ Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural after death. М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Jonathan Weak, M.D. 32. Registrar's Signature State 4 marke Registrar

			State of Maryland / Depa		ental Hygiei	ne on E	01500
			1 - State Registrar Cer	tificate of Death	Reg.	CUU-3M	01332
П	Physicia	an	1. Decedent's Name (First, Middle, Last) ROBERT MARTIN MORRIS	•		Day Year	3. Time of Death
	/Medic	al.	ROBERT MARTIN MORRIS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JAN !	4c. County of Death	1:45 PM
	Examin	er	14117 CAINE STABLE ROAD	OCEAN CITY		WORCEST	ER
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birtho	lace (State or Foreign
	Diréctor		218-34-5062 18 ^{M 2□F} 66 Yrs.		MAY 23	1938 WAS	HINGTON DC
	land wo	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		1	0d. Inside City Limits
	Mary Internation	tor	MD. WORCESTER OCEA	N CITY			1 Yes 2 □ No
	or 28e	Jirec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	ath wi	rai	14117 CAINE STABLE ROAD	21842		JSA	
	er de; items	Funeral Director	A CONTRACT OF A	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	urs aft	by F	3 □ Widowed 4 □ Divorced 14 Sear or Dates: 959	I ☐ Yes 2 No Specify:		Specify:	HITE
2-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-f show than "cical Ext. nither it ust be notified at		15 Decedent's Education 16a Deced	lent's Usual Occupation	16b	. Kind of Business/Ind	
2121	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of workii DO NOT use retired)			
2	filed w Hygier other ti		17. Father's Name (First, Middle, Last)		(First, Middle, Maid		RY COUNTY
and	od tal	o Be	CORNELIUS MORRIS	JOSEPHI			OGES
Maryland	should ind Men s marke umetic	2		g Address (Street and Number or Rura			
	and 2 ealth a n 27 is		LINDA M. MORRIS (WIFE) 14117	CAINE STABLE R	D. OCEF	IN CITY, M.	D. 21842
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposement of State 20c. Place of Disposement of State Montgomery	natory`or other place) Janua	ry 21,	. Location - City or To	wn, State
≣	t. Pac then tent: njury		`4 □Donation 5 □Other (Specify) Crematori	ium. Inc.		thesda, Ma	
Bal	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny injury or other treumetic QUCE.	6 3	21. Signature of Furieral Service Librarsee RC RC M00803 RC	Name and Address of Facility Robotckville, Inc. 30 ockville, Maryland	0 West Mo 20850-2	ntgomery A 805	Avenue
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	1			Approximate Interval Between Onset and Death
	Physician		resulting in death)	alignant Melana	Ma		12 years
	/Medical- Examiner		Due to (or as a consequence of):	7			53
	3 1	ler	Sequentially list conditions, if any, reading to immediate cause. Enter Undertrying Cause (Disease or injury				
	cuted	Examiner	that initiated events C.				
Ö,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	icate be physicii s the bu	dicai	d				
Box 6	certific nding p use as	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
-	that the death certif ed by the attending detached for use a	iciar	in the past 12 months? 1 Ves 2 No. 1 Pedal death 3 Leave birth 2 Pedal death 5 Leave birth 2 Leave	Ectopic pregnancy Other (specify)		Month	Day Year
P.0	at the by the stache	hys	9 Unknown				
	es De pa	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th 2 No 3 □ Prob	ne cause of death?
COL	w requir s been si should	Completed			24a. Was an	24b. Were auto	psy findings available
Re	The lay ate has bage 2	отр			autopsy performed	? death?	mpletion of cause of
Vital Records,		BeC	25. Was case referred to medical examiner?	26. Place of Death			
of <	Physicien: this certificated director,	ပု	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			e 6 ☐Other (Specify	y)
o uc	Jing F	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Division	Attending ir death. ector: After by the fune	fical	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str			t and Number or Rura	l Route Number,
á	s after s after of or of	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	таге)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invanily and manner stated.				
	To the To the Compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	. \		1 Cito 8 MGGT	030619		1/14/05	
	$I_{I_{\mathcal{Y}_{J}}}$		30. Name and address of person who completed cause of death (Item 23a) (Type.		112	1. 1000	21811
	Sta	ate.	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	Realist	arte 1, 138A	CIN TIND.	×1011
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RJ			1 - State Registrar				,		tificate o				_	Reg. No	005	01	533
			1. Decedent's Nan										2. Date of De. Month	ath Day	Year	3. Time	e of Death
	Physici /Medic		Eunic	ce Merr	y-May								Januar	y 2,	2005	04:	19 A. ^M
	Examin		4a. Facility Name		-)		4b. City, Town			of Death		4c. C	County of De	ath	
			Maryland General Hospital 5. Social Security Number 6. Sex 7. Ag			ge (In yrs. la	st hirthday)	If Under 1 Ye		more If Under	24 Hrs.	8 Date of Birt	th	9 Bi	rthplace (Sta	te or Foreign	
	Funeral Director		125-30-1	.817	1 □ M 2 Ž		66	Yrs.	Months Day		Hours	Min.	8. Date of Bird (Month, Da May 13	, Year) , 193		ountry)	unk
	and and		Usual Residence of	10b. Count	,		10c. City,	, Town or Lo	cation							10d. Inside	e City Limits
	Mary -f sho	ţ	MD				Ва	altimo	re							1 / X Y	'es 2 ☐ No
	h the or 28e	Director	10e. Street and No	umber					10f. Zip Cod	0				10g. Citiz	en of What C	ountry?	
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	er dea	Funeral	11. Marital Status		Arm	ed Forces:			Was Decedent of Yes, specify C	of His Juban	spanic Ori n, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	- 1	4. Race - Am Black, Wh	ierican Indian ite, etc.	1,
036	ours after death with the Marylan ral', or Itams 23a or 28e-1 show Examinar must be natified at	þ	1 🕅 Never Mar 3 🗆 Widowed	_	If Ye	Yes 2□ es, Give er or Dates:		unk	1⊡Yes 2XXII	No	Specify:			5	Specify:	black	
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Maryland 21215-0036	should be filled within 72 hours atter death with the Maryland and Mental Hygiene. narkad other than "netural", or Itams 23a or 28e-f show americ event, the Medical Examinar must be notified at	To Be (17. Father's Name	e (First, Middle	, Last)				un	k	18. Mothe	er's Name	(First, Middle,	Maiden S	Sumame)		unk
ary	shou and M e mar	-	19a. Informant's N	Vame/Relation	ship (Type, Prin	nt)		19b. Mailir	ng Address (Stre	eet ar	nd Numbe	er or Rura	l Route Numbe	er, City or	Town, State,	Zip Code)	
Ž	and 2 ealth a n 27 is		Marylan	d Gener	al Hosp	ital		827	Linden	Av	venue	Bal	timore,	MD	21202		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netureny injury or other treumetic event, the Madical Once.		20a. Method of Di	☐ Cremation	3 □Removal Specify) in	from State	ce.	ace of Dispo metery, crer	sition (Name of natory or other p	f place)	D	ate	20c. Loc	ation - City o	r Town, State	9
Baltii			21. Signature of F			asant		St	Name and Ad	ato	mv B	oard	655 W.	Bal	timore	Stree	t.
			23a Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approxim										mate				
	Physician		Immediate Cause	(Final			sclero	tic c	ardion	11/	101.1	am	disen	10		Onset a	Between nd Death
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ord	equir sen si ould	ted											10,	Yes 2L	No 3□F	Probably 4	Unknown
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ital	ien: artifica ctor, p	Be C	25. Was case references	erred to medic									(Check only o	nne)			
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r o	ing P	:uo	27. Manner of Dea	5 Pend	ing	Date of Inj (Month, D	ay Year)	28b. Time o Injury	1	njury Work	at ?		28d. Describe I	now injury	occurred		
<u>s</u>	ttend death tor: /	icati	2 Accident	6 ☐ Could	tigation I not be	Place of Ir	siun, At hor	mo form et	M 1 reet, factory, offi		′es 2 □	-	28f. Location (Street and	Number or I	Rural Poute A	lumber
Divi	tal or A	Certif	4 Homicide	deter	mined 289.	building, e	etc. (Specify))	eet, ractory, oiii	ice			City or Tox	vn, State)	realition of t	Turar rioure r	(41110-6)
	To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical Certification:	29a. Certifier (Check only one)	1☐ Certify 2☑ Medica	ing Physician: Il Examiner: On and	To the besi the basis d manner s	of examinati	vledge, deat ion and/or in	h occurred at the vestigation, in m	e time	e, date ar inion, dea	nd place, a	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	as stated. le to the caus	se(s)
	To th within To th compl	Me	29b. Signature ar				_				number					oth, Day, Yea	r)
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			30. Name and ad				death (Item	23a) (Type,	Print) 111 D	onr	n C+~	•eet	Baltin	0020	Mare, 1	and 21	201
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician** Margaret T. McKernan January 11, 2005 7:50 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Oakcrest Village Baltimore Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 17, 1920 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2፟ F 84 Yrs. 214-16-3210 Director Maryland Usual Basidence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 1 No **Funeral Director** 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 8830 Walther Blvd 21234 USA Wes Decedenf Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: white 3 Nidowed 4 Divorced largaret McKer permit. Peges 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural" any injury or other traumatic event, the Mental Ponce. 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clerk Federal Reserve 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank J. Suter Margaret Fortney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Margaret Embardino/daughter 3227 Eastbend Court Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of All Chony Process Lipensee 1 easant 28 Marter Affatt of Byill Board 655 W. Baltimore Street Baltimore, MD 21201 san 23a. Pert1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) month Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician end for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. thet initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? COPP 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Tos 2LZ No 1 ☐ Yes 2 ☐ No After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home edical Certification: To 1 Yes ome 5 Residence 6 Other (Specify)
28d. escribe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? Natural 2 Accident 5 Pending investigation nours after death.

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y filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D complataly filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 January 13 2005 Parkula MO 21234 30. Name end and ss of person who completed cause of death (Item 23e) (Type, Print) 8860 Blud Wa (th Landeman mo 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State JAN 2 4 Registrar

		•	For Amend	Item 24	State of Mar a per Verb	yland / Dep . , G839, O	artment of He	ealth and Me	ental Hygien	e 2005	01535
	Physici	an	1. Decedent's Name (Fi			ELSON	/		2. Date of Death	ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not	institution, give s		netion	4b. City Town, or L	ocation of Death		c. County of Deat	
	Funeral		5. Social Security Numb		7. Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth	9. Birti	hplace (State or Foreign untry)
L.	Director	2	Usual Residence of Dec	cedent) 4 Yrs.			3-15-5	OBO	MSUS)
	Marylan Fe ehow Ifed at	tor	10a. State 10l	b. County		Po 1+	imore)			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other then "natural; or itams 23a or 28e-f ehow traumatic event, if a Macical Examina must be indiffed at	i Director	10e. Street and Number	244	Maran	0+ S+.	10f. Zip Code 2.12.	5	10g. (Citizen of What Co	untry?
	er death Itams 23 ner mus	Funerai	11. Marital Status		2. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
0036	nours afturial, or	þ	1 Never Married 3 Widowed 4]Divorced	1 Yes 2 No If Yes, Give Year or Dates:			Specify:		Specify: B	lack
215-(thin 72 the	Completed	15. (Specify of Elementary/Secondary	Decedent's Education of the property (0-12)	cation completed) College (1-4or 5+)	(Give	edent's Usual Occupati e kind of work done du DO NOT use retired)	on ring most of working	y 16b.	SOCIO	Industry
d 21	be filed within 72 tal Hygiene. d other then "nafevent, Ire Wadie.	0)	17. Father's Name (Firs	t, Middle, Last)	years	cust	mer Serv		First, Middle, Maide	on Sumame)	uking
laryland	should be nd Menta i marked imatic ev	To B	Emmer.	SON S	taubury		PSON Ing Address (Street an	Rebai	B.Ed	Or Town State 2	Sin Code 2 12 (78
>	1 and 2 s Health an em 27 ls i ther traus	-	Tanne	Green	(Daught	ler) 790	9 CrisTon	•	At-K	filew	HUMD
altimore,	of or or		20a. Method of Disposit 1 Burial 2 Ci 4 Donation 5	remation 3 🗆 R	emoval from State	20b Place of Disp cemetery, cre	matory or other place)	ak 1/2	405 P	cocation - City or	1 (A)
Balti	permit. Page Department of Importent: if any Injury or once.		21. Signatura of Funera			7	ame and Address	Circu	e Fun	ralSen	21212
1	1		23a. Part1. Inverthe d shock, or neart fai	isease, or compli	tions that caused the cause on each line.	ne death. Do not en	Her the mode of dying,	such as cardiac or	respiratory arrest,	0-100 .	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	al a	SEPS Due to (or as a c	consequence of):					IDAY
	Examiner	16	Sequentially list conditi- if any, leading to immed	ons,	ACVTE Due to (or as a c	RENA consequence of):	L FAILL	RE			1 DAY
	be executed sician and burial-transit	Examiner	cause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last	g d	Thror Due to (or as a c	nbocy	Openia				1 DAY
,092	death certificate be executed e attending physician and ed for use as the burial-transit	icai E	is a second of the second of t		Nev	M)Den	12				1 DAY
Вох 68	leath certifica attending ph I for use as th		IF FEMALE: 23b. Was decedent pre	egnant 2	3c. If yes, outcome of					23d. Date of deli	very
о. В	the atter	Physician/Med	in the past 12 mor 1 2 Yes 2 2 No 9 2 Unknown	iths?	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
s, P.(Physician: The law requires that the de, this certificale has been signed by the a ral director, page 2 should be detached f	by Ph	Part II. Other significan	nt conditions cor	tributing to death but	not resulting in the	underlying cause given	in Part I.		_	the cause of death?
Records,	w requir s been si should	Completed	_ CYIY GYI I	(DO	CK Juli	<i>)</i>			1 ☐ Yes 24a. Was an	24b. Were au	topsy findings available
al Re	: The lav								autopsy performed? 1 Yes 2 □ N	death?	2 No
f	ysician: Th nis certificate director, pag	To Be	25. Was case referred the examiner? 1 ☑ Yes 2 ☐ No	 	ospital: 1 Inpatient	2 ER/Outpatie	Other	26. Place of Death 4 ☐ Nursing Hom	Check only one) B S Residence	6 ☐ Other (Spec	city)
o uo	iding Phys th. : After this funeral di		27. Manner of Death 1 Natural 5 2 ☐ Accident	Pending investigation	28a. Date of Injury (Month, Day Y	'ear) 28b. Time (Work?	st 2 □ No	d. Describe how in	ury occurred	
Division of Vital	f or Attendi after death. Diractor: A I in by the fu	Certification:		Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, si (Specify)	treet, factory, office	28	Bf. Location (Street and City or Town, Sta		ral Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page						th occurred at the time				
	Fo the H within 24 Fo the F complete	Medical	one) 29b. Signature and little	1	and manner state	d.	29c. License r	number	29d. D	ate signed (Month	n, Day, Year)
ŧ				The state of the s	ZMD.	th (lines son) T	RES Print) JOVERST	000	Jar	NARY 16	,2005
			30 Name and address CHRI STOPHE	R KO	H, 3001	S. Hon	JOVER ST	-, Balt	imore, h	UD 2	11.225
:0	Sta Registr		JAN 2	4 2005	32. Registrar's	s Signature	E)				

Michael Nath

			_	/pe or Print in B State of Maryland						•
		1	For State Registrar		•	ate of l			Reg. No.2 0 (05 01536
	Physicia	an	1. Decedent's Name (First, Middle, Last)		1.			2. Date of De Month	Day	3. Time of Death
	/Medic	al -	MI C 4a. Facility Name (If not institution, give st		Nuth	City Town or	Location of D	eath	4c. County of	005 5/15 PM
	Examin	er	m m	ARE HOSP	:TAI	Rose	1 1		BAI	TIMORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	Mon	nder 1 Year	If Under 24	Hrs. 8. Date of Bi	4, 1943	9. Birthplace (State or Foreign Country) Maryland
ļ,	Director	L .	218-40-2009	^{M 2□ F} 61	Yrs.			rep. I	4,1943	Maryrand
	yland how		10a. State 10b. County Baltin		Town or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma 18a-f s	ecto	ПО	ЮГЕ		. Zip Code			10g. Citizen of W	
	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "netural", or itams 23a or 28a-f show avent, I'm Medical Evan, extremate recities of	Funeral Director	10e. Street and Number 307 Stillwater	Road	10	212	21		USA	That Court y
	death	nera	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	. 13. Was D	ecedent of H	ispanic Origin' n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	o- 14. Race Black	- American Indian,
20	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		s 20 No				White
0500-0	filed within 72 hours after Hygiene. other than "natural", or ita ant, the Medicel Evantor.		15. Decedent's Educ	ation	16a. Decedent's	Usual Occup	ation during most of	working	16b. Kind of Bu	siness/Industry
N .	ithin 7. le. lan "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Service	OT use retired	1)	Working	Honey	wellSecurity
7	filed w Hygier thar th		8th 17. Father's Name (First, Middle, Last)		PELATO	e Man		Name (First, Middle	, Maiden Sumame	9)
and	lid be kad o ic ave	o Be	John J. Nuth S	Sr.			Dorot	thy Appe	1t	
ary	s 1 and 2 should be I Health and Mental Itam 27 is markad othar traumatic av		19a. informant's Name/Relationship (Typ	e, Print)	19b. Mailing Add	iress (Street	and Number o	r Rural Route Numb	per, City or Town,	State, Zip Code)
ອ ໜົ	1 and Health Iam 27 othar tr	-	SAndra Nuth /wi		307 S		ater I	Road Bal		MD City or Town, State
	Pages nent of hint: If Its		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	metery, crematory yviewCr	or other place		122/05	Baltin	
baltimo	그 문 뿐 글	-	21. Signature of Funeral Service License			e and Addre	7 E - 10 -			LHomeofEssex
מ	permi Depa Impo any ir		1. Terry	Connell	4 3	00 Ma	ce Av	e. Balti	more MI	
			23a. Part1. Enter the disease, or competence, or heart failure. List only on Immediate Cause (Final	ations that caused the death.	not enter the	mode of dyin	g, such as car	rdiac or respiratory a	arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	M 4 Due to (or as a consequ	ence of):					
	Examiner		Sequentially list conditions b.	Occlusion	OF CO	RONA	RY 57	TenTs		
Į,	pe sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Occlusion Due to (or as a conseque ARTERIOSC)	ence of):		1)		D.	
	executed in and rial-transit	Exan	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):	CAR	CIOVA	SCULAR	DISCAS	
09/80	ysiciau	cal	€ d.							
	eath certificate be exe attending physician ar for use as the burial-t	an/Medi	IF FEMALE:	c. If yes, outcome of pregnar	len.				22d Date	of delivery
X D	death c	O	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 □Ector	oic pregnancy or (specity)			Mon	of delivery hth Day Year
	the by th ache	Physi	9 Unknown	9 Unknown						
S.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ributing to death but not resu	Iting in the underly	ing cause giv	en in Part I.		4	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
cords		eted						24a. Wa:		Vere autopsy findings available
Z Z	The law ate has b bage 2 sl	ompleted						auto	opsy pormed? d	rior to completion of cause of eath? □ Yes 2 □ No
VII		Be Co	25. Was case referred to medical					Death (Check only		200
	> .º 0	으	THE 2 NO		P/Outpatient 3		4 🗀 Nursii	ng Home 5 Res		
000	ding Fith.	tion:	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injur Wor 1 []	yat k? Yes 2 □ No		how injury occurre	
UNISION	er deal ractor by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fa	ctory, office			(Street and Number	or or Rural Route Number,
5	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	I Cer	29a. Certifier Certifying Phys	ician: To the best of my know	vledge, death occi.	urred at the tir	ne, date and p	place, and due to the	cause(s) and mar	nner as stated.
	the Hos hin 24 ho tha Fun npletely	edical		er: On the basis of examinati and manner stated.					, date and place, a	nd due to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier			29c. Licens			29d. Date signed	(Month, Day, Year)
			TO THE STATE OF TH			NE	5 00	000	11,010	

State Registrar

DR. SUMMER ABOL - Meged 9000 FRANKLIN SQUARE DR. BAITIMORE Md 21237
31. Date filed (Month, Day, Year)

1AN 2. 4 2005

May Summer About

1 AN 2. 4 2005 JAN 2 4 2005 DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State of Ma		artment of He			iene •g. No. 200	5 0100-
	Physici /Medic		Decedent's Name (First, Middle, Last)	S. Posto	n		2. Date of Deat Jan 20	th _	3. Time of beath 2325 M
	Examin		4a. Facility Name (If not institution, give street and number) Gilchrist Center		4b. City, Town, or L	า		4c. County of Dea	
	Funeral Director		5. Social Security Number 22018-7668 6. Sex 1 M 2 F 7. Age Usual Residence of Decedent	9 (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan27	, 1927 Mar	rthplace (State or Foreign ountry) Y Land
	ith the Maryland or 28a-f show is notified at	tor	10a. State MD 10b. County Baltimore	10c. City, Town or Lo	Essex				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show rmust be routhed at	Funeral Director	10e. Street and Number 1008 Mace Ave,		10f. Zip Code 2122	21	11	0g. Citizen of What C	ountry?
036	P # 2	by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 3 Married 1 Never Married 4 Married 4 Married 1 Never Married 4 Married	lo l	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🛱 No	panic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify₩hj	ite, etc.
Maryland 21215-0036	within 72 horane. Inan "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	16b. Kind of Business Marine T					
ıland 2	uld be filed Aental Hygie irkad other itic evant, II	To Be Co	11th 17. Father's Name (First, Middle, Last) Frank S. Poston	Marine Terminal (First, Middle, Maiden Sumame) Mason					
Man	nd 2 sho Ith and N 27 is ma		19a. Informant's Name/Relationship (Type, Print) Robin Jackson		ng Address (Street and 4 PebbleB			-	
Baltimore,	ages 1 ar ant of Hea nt: if itam 3		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	1/24	ate :	20c. Location - City or Baltimore	Town, State
Baltin	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee	1	2. Name and Address	of Facility Co		FuneralH more MD	omeofEssex
	Physician		23a. Part1. Enter the disease, or complice fions that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	the death.—Do not en	ter the mode of dying,				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as,	a consequence of):		110010			Jas
1325 8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
0-05 0. Box 6	death certifi ie attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
رگ – rds, P	es ngi	by	Part II. Other significant conditions contributing to death bu	ut not resulting in the u	inderlying cause given	in Part I.	23e. Did tob	oacco use contribute t os 2 ⊠No 3 □ P	o the cause of death? robably 4 Unknown
ard I Recor	sician: The law requ certificate has been rector, page 2 should	Completed					24a. Was ar autops perform 1 ☐ Yes 2	y prior to death?	utopsy findings available completion of cause of
Richar In of Vital R	Phys rthis ral di	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatie 27. Manner of Death 1 Natural 5 Pending		nt 3 DOA Other: of 28c. Injury a Work?	at 2	(Check only one	θ)	poly) Hospice
aston, Divisio	i or Attanding after death. Diractor: Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injuding, etc.	ıry - At home, farm, st. c. (Specify)		es 2 No	8f. Location (Str City or Town	reet and Number or R n, State)	ural Route Number,
024	To the Hospital or Attanowithin 24 hours after death To the Funaral Director:	Medical C	29a. Certifier 1 Certifying Physicien: To the best consistency one) 1 Medical Examiner: On the basis of and manner sta	examination and/or in	h occurred at the time, vestigation, in my opin	, date and place, a nion, death occurre	nd due to the ca d at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
•	To the vithin To the comp	W	29b. Signature and title of certifier Mathyny (1)	ley, m	29c. License r		-	and Date signed (Month	
1	7		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, 670)	Ar-Char	les St.	Balto	Md 21	21,2005
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 2005 32. Jegistra	r's Signature	porte				

		•	For State (of Marylar		artment of rtificate c		ınd Me		iene 005	01538
	Physicia	an	Decedent's Name (First, Middle, Last)	и D.					. Date of Deat	Day 2005	3. Time of Death 5:25p M
	/Medic	al	Bernadette 4a. Fecility Name (If not institution, give street and n		etrovi		n, or Location of		Jan. 19	4c. County of Deal	
	Examin	er	3932 North Point Ro				Ltimore			Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 175-36-8493	7. Age (In yrs. 5 8		If Under 1 Ye Months Da		Min. 8	Date of Birth (Month, Day Sept. 1	9. Bird 6, 1946	hplace (State or Foreign untry) PA
	ס		Usuel Residence of Decedent	140.0							10d. Inside City Limits
	anylar show	5	MD 10b. County Baltimore	100. 01	ity, Town or Lo	Balti	more				1 ☐ Yes 2 ☐No
	the M	Director	MD Baltimore 10e. Street and Number			10f. Zip Cod			1	0g. Citizen of What Co	untry?
	3a or	Ö	3932 North Point Ro	oad		2122	22			USA	
	deat	Funeral	11. Marital Status 12. Was De	cedent Ever in U	J.S. 13.	Was Decedent	of Hispanic Orig Juban, Mexican,	gin? (Specir , Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28e-f show eumatic event, the Medical Examinational to notified at	by Fu		2 X No Sive		1 □ Yes 2 X I				Specif W hi	te
9	2 hou		15. Decedent's Education		16a. Dece	dent's Usual Oc	cupation ne during most tired)	of working		16b. Kind of Business	Industry
215	ithin 7	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)		po Not use re nemaker		or working		own home	
7	iled w Hygier ther th	Co	17. Father's Name (First, Middle, Last)		11011	- I Cilianoi		r's Name (/	First, Middle, M	Maiden Sumame)	
Maryland 21215-0036	od ia b	To Be	Thomas Becker				Do	oroth	ny Qui	nn	
lary	item 27 is marke other treumatic.		19a. Informant's Name/Relationship (Type, Print)							, City or Town, State, 2	
	1 and Health Iem 27 other tr		Dominic C. Petrovia 20a. Method of Disposition			2 Nort		nt Ro		11timore 20c. Location - City or	MD Town, State
more,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	n State	cemetery, crei	natory or other. Cremat	place)	1/20,	. 1	Baltimor	
Baltir	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licensee	.11		2. Name and Ad	dress of Facility	COIII	nellyE . Balt	TuneralHo	meofEssex 21221
			23a. Part1. Enter the disease, or emplications that shock, or heart failure. List only one cause on	caused the dea	th Bo not ent		dying, such as o				Approximate Interval Between
	Physician	Q G	Immediate Cause (Final disease or condition	east	Caro	inor	us N	nich	rsta	tic	Onset and Death
	/Medical Examiner		resulting in death)	o (or as a conse	quence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consec	quence of):						
	ecuted ind transit	Examiner	that initiated events c.	- (
8760,	cate be executed physician and the burial-transit	al Ex	Due (c	o (or as a conse	quence or):						
687	tificate ig phys as the	edical	d								
ŏ	death certific e attending p ed for use as	an/M	23b. Was decedent pregnant	utcome of pregn		DEctopic pregna	incy			23d. Date of del Month	ivery Day Year
O. B	0 0	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	gnant at time of a mown	death 5	Other (specify)			Worth	Day 13a.
S,	that the dened by the a	by Ph	Part II. Other significent conditions contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	pacco use contribute to	the cause of death?
ords	w requires that s been signed b should be deta								1 □ Ye	es 2. No 3 □ Pr	obably 4 Unknown
Record	The law requires that the tee has been signed by the bage 2 should be detache	Completed							24a. Was a autops perform	y prior to	topsy findings available completion of cause of
			25. Was case referred to medical				OC Place	of Donth (1 ☐ Yes	Yes 1 □ Yes	2 No
Vita	s certi	To Be	examiner?	Inpatient 2	ER/Outpatier	nt 3 DOA	Other		Check only on		cify)
Division of	ng Phy fter thi neral		27. Manner of Death 1 Natural 5 Pending (Mc	e of Injury onth, Day Year)	28b. Time o		njury at Work?		d. Describe ho	ow injury occurred	
20	death. stor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At h	home farm st		1 Yes 2 N		f Location (St	reet and Number or Re	ural Route Number.
<u>></u>	after of Direct of in by	Certification:		Iding, etc. (Speci	ify)	eet, factory, off	ice.	20	City or Town		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1. Certifying Physicien: To t (Check only one) 2 Madical Exeminer: On the	he best of my kn basis of examin anner stated.	nowledge, deat nation and/or in	h occurred at th	e time, date and ny opinion, deat	d place, an	d due to the call at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier		1	29c. Lic	ense number	. (2	9d. Date signed (Mont	h, Day, Year)
	,		Kathum / Co	Ww	er	10.	5614	16		1-20-	1005
	5		30. Name and address of person who completed ca	use of death (Ite	m 23a) (Type,	Frint)	Cours	Ch	275	Breen H	Bal biners
	Sta	ate	31. Date filed (Month, Day, Year) 32.	Registrar's Sign	nature	The same of	wire.	. 40	1 Con	. Tue of	MUZIZO
	Registi	rar	JAN 2 4 2005	321481	15 19	All The State of t					

			1 - For State Registrar	State of Maryla	,	ertificate of		Mental Hy	giene Reg. No	6000	01539
	Dhysisi		1. Decedent's Name (First, Middle, Last					2. Date of De Month	aath Da	y Year	3. Time of Death
	Physici /Medio			sko				Oi.	18		
	Examir	er	4a. Facility Name (If not institution, give Johns Hopkins Baynien	street and number) Mediccul (euc	ta	Baltik				County of Dea	ath
	Funeral Director		218–14–5823	7. Age (In yrs	s. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da 11/01/	th ay, Year, 1924	9. Bi Mai	rthplace (State or Foreign Country) Cyland
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor		City, Town or L	ocation.					10d. Inside City Limits 1 ☐ Yes 2 No
	28a-	Funeral Director	Maryland Baltimor 10e. Street and Number	e Eu	genere	10f. Zip Code			10g. Ci	tizen of What C	Country?
	h with	o ie	7108 River Drive R	oad		21219			Uni	ted Sta	ated
	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	. Was Decedent of H	lispanic Origin? (S	pecify Yes or No	D-	14. Race - Am Black, Wh	
036	ours after ral', or ite Examin	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:			Specific	nite
21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hyglene arked other than "natural", or Items 23a or 28a-f show afte event, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NDT use retire	during most of wor	king	16b. K	(ind of Busines	s/Industry
	should be filed withir nd Mental Hyglene. marked other than imatic event, the M	Con	6		Homer	naker				nestic	
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan				
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic	은	August Kordek	91.4	401-14-1			ne Mysz			The Condo
a N	nd 2 sho aith and 27 is m		19a. Informant's Name/Relationship (T)			ling Address (Street					
	is 1 and of Health item 27 other tr		Michael Kordek - N 20a. Method of Disposition			B Wright a position (Name of penatory or other place		Date		ocation - City o	
5	Pages nent of I nnt: If its ury or o		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval irom State	. Stani	_		2/2005			, Maryland
Baltimore,	2 5 t 2 7 .		21. Signature of Funeral Service Licens		0 12	22. Name and Addre	ss of Facility				racyland
ä	Depa Impo any ir		* Kathlean 11	John CIS		David J. N 101 South	Weber Fur Chester	eral Ho Street	mes Ralt	P.A.	MD 21231
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	/Medical		resulting in death)	Due to (r as a conse	equence):	et built					
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). Box	s death certificate be executed he attending physicien and ted for use as the burial-transit	Physician/Med	in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify) _	,			23d. Date of de Month	olivery Day Year
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ō	Phys this al dii	2	1 ☐ Yes 2 No 27. Manner of Death	lospital: 1 npatient 2[28a. Date of Injury	ER/Outpatie		4 Nursing n	ome 5 Resi			ecify)
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=	f or Attending after death. Director: After I in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec				28f. Location (City or To			Tural Route Number,
	To the Hospital or Attenvithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		sician: To the best of my kr ner: On the basis of examinand manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Da	te signed (Mon	th, Day, Year)
•	->-0		M.EQ_		10	RE	-000		Jan	icity, 184	Hi, 2005
1	ı		30. Name and address of person who co	empleted cause of death (Ite	om 23a) (Typo	Print) dical Couter,	4940 Easte			· · · · · · · · · · · · · · · · · · ·	
	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's Sign		1					

			1 = For State Registrar	State of Marylan	d / Depa	artment of H	ealth and Death		giene Reg. No. 200	05 01540
	Physici	an	1. Decedent's Name (First, Middle, Last) Harold Price					2. Date of Dea Month	Day Ye	
772	/Medic Examir	~/6	4a. Facility Name (If not institution, give s Prince George		iter	4b. City, Town, or Cheve		Januar	4c. County of E	
2	Funeral Director		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Birtl Min. (Month, Day Oct 24	, Year) 9.	Birthplace (State or Foreign Country) Maryland
	show ed all	or.	Usual Residence of Decedent 10a. State 10b. County MD Prince G		y, Town or Lo					10d. Inside City Limits
	with the h	i Director	10e. Street and Number 6819 Seat Pleasan	t Drive		10f, Zip Code	0747		10g. Citizen of Wha	t Country?
920	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "naturel", or Itams 23e or 28e-1 show event, the Medical Examinat must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:				? (Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	within 72 ho ene. than "natur ta Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) unk		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of	working	16b. Kind of Busin	ess/Industry
land 2	2 should be filed and Mental Hygic is marked other aumatic event, II.	To Be Co	17. Father's Name (First, Middle, Last)			unk	18. Mother's	Name (First, Middle,		unk
Mary	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty, Shirley Hamilton/f			•		r Rural Route Numbe Gardenda		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 ti any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 ☒ Other (Specify)	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	e)	Date	20c. Location - Cit	y or Town, State
Balt	permit. Departitimport		21. Signature of Funeral Service License	Teasant	Ba	altimore,	MD 21	ard 655 W. 201		1
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	PATHY					Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien end of for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of): HEA uence of):	RT FAIL	URE			
Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
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Division	De Se	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str y)			28f. Location (5 City or Ton		or Rural Route Number,
	Hospite 4 hours Funeral	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	581	82	29d. Date signed (A	· · · · · · · · · · · · · · · · · · ·
			30. Name and address of person who or . DONALD GEOR (31. Date filed (Month, Day, Year)	- \	300/	Print) HOSPITA	1 DR	NE C	HEVERLY,	10 - 05 MD 20185
	Sta Regist		JAN 2. 4. 20	195 Bure	S. A.	parke				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 1:15 PH **Physician** Tanuary 21 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death (If not institution, give st Examiner timore) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Director Jarylani 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of Whet Country? Peges 1 and 2 should be filed within 72 hours efter death with Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n end Mentel Hygiene. is merked other than College (1-4or 5+) WORKE 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (5 t of Health If Item 27 i or other tra Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Depertment of Important: If It any injury or c 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MD 2/229 23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Approximale Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ears Examiner Physician/Medical Examiner ettending physicien and for use es the buriel-trensit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? cete has been sig ; page 2 should b 24a. Was an autopsy performed? Be Completed 1 Yes 1 ☐ Yes 2 ☐ No within 24 hours efter deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D13657 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) MACGREGOR, 48 H STREET, BALGIOVERE, MOD 2121' 700 W. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 4 2005

Registra

GOBALL

Amend item#29c, 30, per DVR, G839, 1/24/05 TT
State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 9:32AM **Physician** Kukuna 2005 Jan /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/04/1921 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 K GERMANY 84 Director 219-32-2582 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other then "naturet", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MONTGOMERY ROCKVILLE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 U.S.A. 6121 MONTROSE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forceç? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Marned WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) HOUSEWIFE OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WOLFE VICTOR MARTHA FRITZ 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5933 CHAPARRAL AVE. SARASOTA, FL. 34243 MARTIN KATZENSTEIN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED | 01/21/2005 | RANDALLSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 (Kum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory tailure unknown **Physician** /Medical Due to (or as a consequenca of): Un Graun Examiner Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine buriai-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ anemia 1 Yes ⊅X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate has Dementia 1 Yes 2 No 1 🗌 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation death. 2 Accident filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi Medicai 29c. License number **D0052713** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 118/200 Internatio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shilpa Amin, Hebrew Home of Greater Washington, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State porte 2005 Registrar

			1 16436	State of Maryland	d / Depa	rtment of H	lealth and	Mental Hy	giene	200		
			For State Registrar		Cer	tificate of l	Death		Reg. No.	2005	015	43
	Physicia	317	1. Decedent's Name (First, Middle, La	est)				2. Date of De Month	Dav	Year	3. Time of De	
	/Medic	al	Frederick Lesli			4b. City, Town, or	Logation of Day	Janua	9 9	5. 205 County of Death	6:41	PM_
	Examin	er	4a. Facility Name (If not institution, git Maryland Gene			0	nore C	140	J	oodiny of Death		
	Funeral Director		5. Social Sedurity Number 6.	Sex 7. Age (In yrs. I 1△M 2□F 63	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		71941	9. Birthp Cour Ma	place (State or F ntry) ryland	oreign
	put *		Usual Residence of Decedent 10a. State 10b. County	10c. Cib	, Town or Loc	ation					Od. Inside City I	Limits
	Maryla f eho	ō	MD N/A	1	altimo						1 ₩Yes 2	□No
	r 28a-	irect	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	th with	alD	3590 Dudley Ave	nue		2121				U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural; or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinat mark to notified at once.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba		(Specify Yes or No arto Rican, etc.)		 Race - Americal Black, White, Specify: Wh: 	etc.	
Maryland 21215-0036	72 hou natura ilcal E	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. Deced	ent's Usual Occup kind of work done OO NOT use retired	ation during most of w	rorking	16b. Kin	nd of Business/In	dustry	
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	and in 27 m 27		Marlene Dieter /		in .			Baltimore Date		ryland :		
Baltimore,	Pages 1 thent of H tant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify) Ba	lto./W	sition (Name of natory or other place ash. Cre	m. 1/	19/05	Lau	rel, Man	ryland	_
Ba	permit Deper impor any in		21. Signature of Functor Server Lice	77				Miller-D: Baltimo:				Lnc.
	/Medical Examiner private the private	Examiner	23a Part1. Enter the disease, or conshock, or heart failure. List only unmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq	Ence uence of):	pholopo	0040	ac or respiratory a	arrest,		Approximate Interval Betwe Onset and De	een ath
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Vita	Physician: rthis certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	5B/0 +	ott	100	eath (Check only			4.1	
	Phys r this sral di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	4 🗀 IAUIZIII	Home 5 Res 28d. Describe			ny)	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying F (Check only 2 Medical Ex- one)	Physician: To the best of my know aminer: On the basis of examina and manner stated.	wiedge, death tion and/or inv	vestigation, in my o	opinion, death or	ace, and due to the courred at the time	, date and	place, and due	to the cause(s)	
}	To t With To t	Σ	29b. Signature and title of certifier	e MD)	29c. Licens	498			e signed (Month)		
	4		30. Name and address of person wh	o completed cause of death (Iter			cal ila	ا مدن				
	Sta	ate	31. Date filed (Month, Day, Year)	3. Registrar's Signa	TU ON		ral Hos	priaci				
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DH	MH 17 Rev 1/2	001										

ORIGINAL

## Funeral Director Funeral D	2005 8: 45 M of Death 1 M O C 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Tyes 2 No hat Country? 4 American Indian, 5, White, etc. 2006 3006
4. Facility Name (if not institution, give street and number) 4. Cuty, Town, or Location of Death 4. Cuty, Town, or Location 5. Social Security Number 4. Social S	9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Tyres 2 No hat Country? 4. American Indian, 4. White, etc. 100 CK 100 C
10a. State 10b. County 10c. City, Town or Location 10c. Ci	1 Ty Yes 2 No hat Country? USA - American Indian, ., White, etc. Block siness/Industry Lty Schools State, Zip Code)
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shock, or heart failure. List only one cause on each line. Immedical disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Usease or injury that initiated events resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): C. How we have the property of the propert	mo 21133
Due to (crass a consequence of):	Approximate Interval Batween Onset and Death Color - Moville Michigan Color
	of delivery
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	,
	oute to the cause of death?
1 Yes 2 No 3 Pr 24a. Was an autopsy performed? death? 1 Yes 2 No 3 Pr 24a. Was an autopsy performed? death? 1 Yes 2 No 3 Pr 24b. Were au prior to death? 1 Yes 2 No 3 Pr 25. Was case referred to medical examiner? 1 Yes 2 No 3 Pr 26. Place of Death (Check only one) 27. Wasner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	ere autopsy findings available or to completion of cause of ath? Yes 2 No
25. Was case referred to medical examiner? 1	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Whursing Home 5 Residence 6 Other (Specific Policy of Town, State) 26. Place of Death (Check only one) 27. Manner of Death 1 Natural investigation 3 Suicide 4 Homicide of Colld not be determined of the determin	(0/-)
27. Manner or Dearn 28d. Date of Injury	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month)	or Rural Route Number,
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E Light B 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month	or Rural Route Number, ner as stated. d due to the cause(s) Month, Day, Year)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) 29d. Date signed (Month)	or Rural Route Number, ner as stated. d due to the cause(s) Month, Day, Year)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	or Rural Route Number, ner as stated. d due to the cause(s) (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** JANUARY 2:15 August C. Schott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 218-10-7884 September 9, 1919 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1√ Yes 2 No Maryland N/A Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21206 USA 3920 Wilke Avenue by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 ☑ No Specify White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tool & Dye Maker Western Electric 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be lillian Kriss Louis Schott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 832 Ring Factory Road Joppa Maryland 21085 Warren Hardiman/Son in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Highview Memorial Gardens 1/24/05 Bel Air Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 hrestina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exar iner burial-trar sit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗆 No 3 Probably 4 □Unknown SEPSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA filled in by the funeral Marher of Death 28b Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28c. Injury at Work? Certification: After t or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 15 rella mo DAIN 20 D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrer	State of I		eartment of Hea		ntal Hygier	7 11 11	5 01546			
			Decedent's Name (First, Middle, L	ast)			2	. Date of Death		3. Time of Death			
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	/Medic Examir		4a. Facility Name (If not institution, g			4b. City, Town, or Loc			4c. County of E				
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	Funeral		5. Social Security Number 6.		Age (In yrs. last birthda)) If Under 1 Year If I		. Date of Birth (Month, Day, Yea	ar) 9.	Birthplace (State or Foreign Country)			
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	pur *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or I	ocation				10d. Inside City Limits			
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	ns 23	Funeral	3314 Hillsmer	12. Was Decede	nt Ever in U.S. 13	Was Decedent of Hispar If Yes, specify Cuban, M				American Indian,			
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Jar	d 2 should th and Mer t7 is marke treumatic	1 3	19a. Informant's Name/Relationship			ing Address (Street and I							
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0	50 0		1 Burial 2 Cremation 3		te cemetery, cri	ematory or other place)	1						
Baltimore,			'4 □Donation 5 □Other (Spec		Crownsy	ille Vet.			ownsv	ille, Md			
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			shock, or heart failure. List on	y one cause on each	n line.	iter the mode of dying, so	uch as cardiac or n	espiratory arrest,		Interval Between Onset and Death			
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	/Medical Examiner		resulting in death) Jue to (or as a consequence of):										
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	requires that the peen signed by th hould be detache		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause given in	Part I.	23e. Did tobacc	o use contribut	e to the cause of death?			
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00		lete						24a. Was an	24b. Were	a utopsy findings available			
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⋚		00	examiner?	Hospital: 1 Inpa	atient 2 ER/Outpatie	Othor	. Place or Death (C	1.00	6 COthor (6	Page (64)			
of	Phys r this sral di	: To	27. Manner of Death	28a. Date of I	njury 28b. Time	of 28c. Injury at		d. Describe how in		(pecity)			
on	ding th: Afte fune	t lor	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		Day Year) Injury	Work? M 1 ☐ Yes	2 🗆 No						
Division of Vital Records,	Atter dea octor by the	fica	3 Suicide 6 Could not	A 280. Place of	Injury - At home, farm, s	treet, factory, office	28f			Rural Route Number,			
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying I	hysician: To the be	st of my knowledge, dea	th occurred at the time, d	date and place, and	d due to the cause	(s) and manner	as stated.			
	ne Ho ne Fu ne Fu	edical	(Check only 2 Medicel Excore)	eminer: On the basis and manner	s of examination and/or i stated.	nvestigation, in my opinio	n, death occurred	at the time, date a	nd place, and o	due to the cause(s)			
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	1				f death (Item 23a) (Type	, Print)		010 21					
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State	State of Ma		partment of F <i>ertificate of</i>			21	105	0151.7
			Registrar 1. Decedent's Name (First, Middle, Las	t)		- incate of		2. Date of Dea	Reg. No	100	3. Time of Death
	Physici		Roland		Ε.	S	cott	Month	By 19	JOOS	02:23AM
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)			or Location of Death	1	/	nty of Death	19 00
1	ZAGIIII		STAGNES	HealT	HEAne	BAL	Timo	20			
	Funeral		Social Security Number		e (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birthr	place (State or Foreign
	Director		210-20-1192	XM 2□F	73 Yrs	.]		10 31			MĎ
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				- 1	10d. Inside City Limits
	Maryl f sho	ō	MD		Dolas						1 ☐XYes 2 ☐ No
	28a	rec	MD NA 10e. Street and Number		Baltim	10f. Zip Code	· · · · ·		10g. Citizen o	of What Cour	ntry?
	h with	D E	2230 Athol Roa	đ		21	227		11.	S.A.	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	Was Decedent of H If Yes, specify Cub		pecify Yes or No-		ace - Americ	
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or Items 23s or 28s-f show event, it a Madical Executor must be notified at	by	1X Never Married 2 Married 3 Widowed 4 Divorced	fXX es 2 ☐ f If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣No	Specify:	o nicari, etc.)	Spec	lack, White,	ack
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2	filed withi Hygiene. Ither ther	S	12th grade	na		Tailor				eane	r
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	Head Head		Coretha McNeill 20a. Method of Disposition	-Sister	20b. Place of Di	8 Richnol sposition (Name of	1 1	Baltimo Date	20c. L cation		L212 own, State
lou	0 0		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	crematory or other pla	· 1	F /0F			
Baltimore,			21. Signature of Funeral Service Licen			ville Ve		5/05	Crown	SV11.	le, Md
Ba	permit. Departr Importe any Inje		1 Dunis	B. Ke	ke	March F/ 4300 Wab	H West ash Ave	Balti	.more,	Md	21215
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1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	· Million Space All)				/
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Box	The law requires that the death certifi te has been signed by the attending rage 2 should be detached for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		205-1			23d. [Date of delive	ary
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	(Check only 2 Medical Exam	iner: On the basis of	examination and/or	eath occurred at the tir r investigation, in my c	me, date and place ppinion, death occu	, and due to the o	ause(s) and r	nanner as st	ated.
	To the h within 24 To the f complete	Med	one)	and manner sta	ited.	29c. Licens			29d. Date sign		
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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Ragistrar	State of Marylan		artment of F				05 0154	8
	Physici	_	1. Decedent's Name (First, Middle, Last)	52	MAJDA		2. Date of Deat Month	_	'ear 3. Time of Death	1
	/Medic Examin		4a. Facility Name (If not institution, give Good Samaritan Hos	pital	.,.	Baltimo			4c. County of		
	Funeral Director		5. Social Security Number 6. Se 148–18–4270 Usual Residence of Decedent	х Пм 2×1 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthplace (State or Foreig Country) Pennsylvania	n
21215-0036	be filad within 72 hours aftar death with the Maryland ital Hygiena id other then "natural", or Itams 23a or 28a-f show event, the Medical Exametrational be notified at	eted by Funeral Director	10a. State 10b. County Maryland Baltimor 10e. Street and Number 2911 Conroy Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grav	Apt. A 12. Was Decedent Ever in U Armed Forces? 1 Yes, Give Year or Dates:	16a. Dece		Specify:	Decify Yes or No- to Rican, etc.)		ates American Indian, White, etc. White	
and 2121	illad Hygi other	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Homen		18. Mother's Na	me (First, Middle, I			
Baltimore, Maryland	parmit. Pages 1 and 2 should be filad v Department of Health and Mental Hygie Important: If itam 27 is marked other t any injury or other traumatic event, III ODGS.	To	Vincent Pace 19a. Informant's Name/Relationship (7 Pat Schmidt - Daug 20a. Method of Disposition 1 X Burial 2 Cremation 3 Company 4 Donation 5 Other (Specify 21. Signature of Funcal Service Licenses)	hter Removal from State St	3 Hig Place of Disponentery, cre Stani	phland Roa osition (Name of matory or other pla slaus Cen 2 Name and Addir of the Control	and Number or R ad Seven (ce) netery 01	Date 1/25/05 neral Home	City or Town, St Pennsyl 20c. Location - C Baltimor es P.A.	vania 17360 ity or Town, State re, Maryland	
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0	St	ate	30. Name and address of person who PENEURE A S DOT 31. Date filed (Month, Day, Ygar)	completed cause of death (Ite	m 23a) (Type	e, Print)		ATTMUNI			

			For State Registrar	State of Ma	aryland		ertment of tificate of		and Me		giene 2 (005	01549
	Physicia	an	1. Decedent's Name (First, Middle, Las						2	. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Lillian	SAMBO	USK.	I				1	22	05	12:45 AM
	Examin	er	4a. Facility Name (If not institution, give		enter	_	4b. City, Town,	timo re	of Death		4c. Cour	nty of Death	
	Funeral		5. Social Security Number 6. Se		e (In yrs. las	t birthday)	If Under 1 Yea Months Days		24 Hrs. 8 Min.	Date of Birti	h /, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		214-20-2287 Usual Residence of Decedent	- W 2X	78	Yrs.			1	2/ 16/	1926	Mary	rland
	yland now		10a. State 10b. County		10c. City,	Town or Lo	cation			-			10d. Inside City Limits
	e Maria-fat	ctor	Maryland Baltimor	re	Dunda	alk							1 ☐ Yes 2X No
	s with the	Funeral Director	10e. Street and Number 3458 Mc Shane Way	7			10f. Zip Code 21222				10g. Citizen o Unite	of What Cou ed Sta	•
	death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S.	13. V	Vas Decedent of Yes, specify Cu	Hispanic Original	gin? (Specif	y Yes or No-	14. R	ace - Ameri	
336	d within 72 hours after death with the Maryland jiene, It hen "neturelt, or Items 23e or 28e-f show It shevical Examiner mast be maiffed at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	lo		Yes 2 N			Jan, 6(0.)		oify: Wh:	
2-0	72 ho netur	eted	15. Decedent's Ed (Specify only highest gra-			16a. Deced	lent's Usual Occi kind of work don OO NOT use retir	upation e during mos	t of working		16b. Kind of	Business/Ir	ndustry
21215-0036	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homen		red)			Domes	tic	
9	file Hyg sthe		8 17. Father's Name (First, Middle, Last)			11011101		18. Mothe	er's Name (F	First, Middle,	Maiden Sum		
Maryland	o d ta b	To Be	Ignatius Dylewski		_			Hele	na Jal	kubiak			
Jan	and and sm		19a. Informant's Name/Relationship (7 Bernard Samborski				g Address (Stree Damsel						
	1 and 2 Health tem 27 other tre		20a. Method of Disposition	- 5011	20b. Plac		DalliSe1 sition (Name of natory or other pl		Dat		20c. Location	_	
altimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		atory or other pl cy Cemet		1/26/	2005	Baltim	ore.	Maryland
alti	permit. Pages Department of Important: If I eny Injury or once.		21. Signature of Funeral Service Lice	see 1	-20-	22	Name and Add	ress of Facilit	у_	1		7	7
8	20 E 9 9		23a. Part1. Enter the disease, of companions, companio	Webe	W W-	40)1 S. Ch	ester	Stree	t, Bal	timore	, MD	21231 Approximate
			shock, or heart failure. List only of Immediate Cause (Final		ine death.	Do not ente	er the mode or dy	ring, such as	Cardiac or r	espiratory an	est,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as)	nce of):							
П	Examiner		Sequentially list conditions	b									
	sit ad	iner	Sequentially list conditions, and leading to the districtions. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequer	nce of):							
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a	a consequer	nce of):							
8760,	ate be executed hysician and the burial-transit			d									
9	artifica ing ph e as th	Med	IF FEMALE:									-	
Вох	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Medicai	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnan Other (specify)	су				Date of deliv Month	ery Day Year
o.	at the de by the a tached	hysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown		0	(0,000,000,000,000,000,000,000,000,000,						
S,	es that igned b be deta	by Pi	Part II. Other significant conditions of	,		-	iderlying cause g	iven in Part I.					he cause of death?
ord	w require been si should t		a resischofic car	diovascular c	diseus	٤			- 1	1 Ø Y	es 2 No	3 ☐ Prol	pably 4 □Unknown
of Vital Records,	e law has b	ompleted								24a. Was a autop perfor	sy	prior to co death?	opsy findings available impletion of cause of
tal		e Co	25. Was case referred to medical					26 Place	of Death //		2 No	1 🗆 Yes	2 No
Z	S S	0 B	examiner?	Hospital:	nt 2 EF	VOutpatient	3 DOA O	thon			ence 6 🗆 O	ther (Specia	(y)
n o		on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28	Bb. Time of Injury	28c. ln			d. Describe h	ow injury occi	urred	
Division	ten leat tor: the	ertification;	2 Accident investigation 3 Suicide 6 Could not be		Int - At home	o form stre		⊒Yes 2⊡1		Location /S	treet and Nur	nher or Run	al Route Number,
Div	Dir	ertif	4 Homicide determined	building, etc	. (Specify)	e, iaiii, siie	set, factory, office	,	201	City or Tow			ar riodio rvamber,
	Hos Pur Bly	edical C	(Charle ant)	ysician: To the best of liner: On the basis of and manner sta				and along the at-	Ale	ad also disco a	ause(s) and r late and place	manner as s	stated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. Licer	nse number	-	2	29d. Date sign	ned (Month,	Day, Year)
)			Herrys Bann	m wa			00	05918	-1		1122	108	
	J'		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who of the series o	completed cause of de	eath (Item 2	3a) (Type, I	Print)	Homere	mD	21211			
	Sta	tė.	31. Date filed (Month, Day, Year)	3 Registra	ır's Signatur	е	100	. (Tive		-1-11			
	Registr		JAN 2 4 2005	The server	K	Coa	les						

			1 - For State Registrar	State of Ma		partmen e <i>rtificat</i>			and M	lental Hy	giene	201)5	015	550
			Decedent's Name (First, Middle, Last)							2. Date of De	eath		· · · ·	3. Time o	f Death
	Physici /Medio		Luther	Harrold	Smith					Januar	y 1 ^D 2	, 20	05°	2:14	Рм
	Examir		4a. Facility Name (If not institution, give	street and number)				Location o			4c.	County	of Death		
			Holy Cross Hospita					r Spr	_			ontg		J	
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthda	y) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Da	rth ay, Year)		9. Birthp Coul	olace (State ontry)	or Foreign
	Director		220-34-0407		64 Yrs.					Octobe	r 16,	1940	Virg	inia	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							1	I0d. Inside C	ity Limits
	Marylan f ahow	ō	Maryland Montgome	rv	Silver	Snrine	,							1 🗆 Yes	2 X No
	the 286	Je C	10e. Street and Number	- 7	511701	10f. Zip					10g. Citi	izen of W	/hat Cou	ntry?	
	3a oi	<u>=</u>	3608 Everton Stree	et		2	0906				Uni	ted	Stat	es	
	death me 2	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 10	B. Was Dece	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race	- Americ	can Indian,	
9	or ite		1 ☐ Never Married 2 Married	Armed Forces? 1 ∰Yes 2 □ N If Yes , Give Year or Dates:	∘ 1960-	1 ☐ Yes		n, mexican Specify:	, Puerto	Hican, etc.)			k, White,		
93	72 hours after death with the Maryland haturel; or iteme 23e or 28e-f show dicel Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1963	1 1 1 1 1 1 1 1	220110	эрвину.				Specify:	Wł	nite	
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade		(Gi	edent's Usua ve kind of wo	rk done d	uring most	of work	ing	16b. Ki	nd of Bu	siness/In	dustry	
12	filed within Hygiene. other then ont, the Me	E G	Elementary/Secondary (0-12)	College (1-4or 5-	+)	. <i>DO NOT u</i> . eman	se retirea,				C	onst	ruet	ion	
d 2	Hygi Hygi Sther		17. Father's Name (First, Middle, Last)		101	omar.		18. Mothe	r's Name	(First, Middle				1011	_
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. Fis marked other than "reumatic event, It a Mes	To Be	Albert J. Smith					Mam	ie R	uth Ta	ylor				
ary	shound M	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Ma	iling Address	(Street a	nd Numbe	r or Rura	I Route Numb	er, City o	r Town, S	State, Zip	Code)	
	l and 2 feelth a im 27 is		Jeanette M. Smith	/Wife	3608	Evert	on S	treet	, S:	ilver S	prin	g, M	ary1	and 20	3906
ore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	amousi from State	20b. Place of Dis cemetery, cr	position (Nar rematory or o	ne of ther place) J.	anua	ry 24,	20c. La	cation - (City or To	own, State	
Ĕ	Pag ment ent: I		`4 □Donation 5 □Other (Specify)	emovar nom State	Elizabet	h Cem	etery		200	5	Salt	vill	e, V	irgin:	ia
Baltimore,	permit. Pages. Department of himportent: If ite any injury or of once.		21. Signature of Funeral Service License	ille, Mar	Inc. yland	20850-	-2805								
			23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. M01305 300 West Montgomery Avenue, Rockville, Maryland 20 Appropriate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inter-												ween
	Physician		Immediate Cause (Final disease or condition	Myocar	dial Infa	rctio	n							Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):										
	-Adminici	_	Sequentially list conditions,	Aortic	Dissecti	Lon									
	ted nsit	nlne	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	sclerotio	Hear	t Di	sease					- 4		
Ć,	execun n enc	Examiner	that initiated events cresulting in death) Last		consequence of):										
8760,	death certificate be executed e ettending physicien end id for use as the burial-transit	dlcal	d												
9	ntifica ng ph as th	led	IF FEMALE:												
Вох	leath certific ettending p	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2		☐Ectopic pr	egnancy				2	23d. Date		-	Year
0.	at the dea by the e	Physiclan/Me	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death 5	Other (sp	ecify)					141011		Day	i Gui
مَ	requires that the een signed by th hould be detache		Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying c	ause give	n in Part I.		23e. Did t	obacco u	se contril	bute to th	ie cause of d	jeath?
ds,	uires sign d be	d by								10	Yes 2]No ∶	3 🗌 Prob	abiy 4 ⊠l	Jnknown
Record	≥ _D ∞	lete								24a. Was	an	24b. W	ere auto	psy findings	available
Re	0 5 0	Completed								autop		pr	ior to coreath?	npletion of c	ause of
Vital	lan: The rtificate stor, pag	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o		11		20 140	
of V	Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	ospital: 1 🗌 Inpatien	t 2 ER/Outpati	ent 3 DO	A Othe	r: 4 🗍 Nur	sing Hor	ne 5 ☐ Resid	dence 6	Other	r (Specify	1)	
	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	of 2	8c. Injury Work	at ?	2	28d. Describe I	how injury	occurre	d		
sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			М		es 2 🗆 N	_						
Division	F 8 F C	4 Homicide determined determined building, etc. (Specify)									ber,				
	To the Hospitel c within 24 hours of To the Funerel D completely filled in	ledical	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examir	ician: To the best of er: On the basis of e and manner state	axamination and/or	ath occurred investigation.	at the time in my op	e, date and inion, death	l place, a h occurre	and due to the ed at the time,	cause(s) date and	and man place, ar	ner as st nd due to	ated. the cause(s)
	To the h within 2d To the F	Σ	29b. Signature and title of certifier	a/1-	21 -	290	. License	number			29d. Date	signed	(Month, I	Day, Year)	
•	\		- h- 11			D(00199	924		J	Janua	ry 2	20, 2	2005	
	\BX)		30. Name and iddress of person who co	/		-	Dani	1 041	1 77.0	Cnwi	. M.	1 -	nd c	0010	1 /, Q /.
	-04	to.		,M.D., 15				1, 51.	rver	shring	, Ma	тута	iiid 2	-0160	1404
	Sta Registr		31. Date filed (Month, Day, Year)	ns Mase	w # A	poste									

		1	For State Registrar	St	ate of M	aryland		artment rtificate			and Me	ental Hyg	jiene leg. No.	005	01551	
			1. Decedent's Name (First, Mic									Date of Dea Month	th Day	Year	3. Time of Death	
	Physicia /Medic	al .	PAULINE		5241				_			Janua	1		1 icop M	
	Examin	0	4a. Facility Name (If not institu	Λ	0	mark mark		4b. City, 1	1.1	Location o		(4c. Cour	nty of Death		
				6. Sex		ge (In yrs. la		If Under	- 6 1.	If Under 2		8 Date of Birth)	9 Birtho	lace (State or Foreign	_
	Funeral Director		5. Social Security Number	1 M		84	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Pay Apr 10,	1920	Cour	unk unk	
			218-09-3791 Usual Residence of Decedent					lL								_
	yland		10a. State 10b. Cou	nty		10c. City,	Town or Lo							1	0d. Inside City Limits	
	e Mar a-f sl	cto	MD				Bal ₁	timore							1. Yes 2 No	
	ith the	Director	10e. Street and Number					10f. Zip	Code				10g. Citizen o	of What Cour	ntry?	
	ath w	ia.	3330 Wilken		e Vas Deceden	Function II C	12	Man Dagard	ant of H	21229		oifu Vos or No-		USA Race - Americ	ean Indian	_
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diest Examiliter mat be natified at	by Funerai	11. Marital Status1 ☐ Never Married 2 ☐ M3 ☐ Widowed 4 ☐ Divor	larried 1	Amed Forces Yes 2 Yes, Give Year or Dates:	?]No u	nk	ovas Decedural of Yes, special of Yes, special of Yes 2	ify Cuba	n, Mexican	n, Puerto F	cify Yes or No- Rican, etc.)		Black, White,		
5-0036	72 hours natural',		15. Dece	ient's Educatio	n (16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of workin	unk	16b. Kind of	f Business/In	dustry unl	k
200		pie	(Specify only hig Elementary/Secondary (0-1		npierea) College (1-4or	5+)	life.	DO NOT us	e retired)	E OF WORKIN	'9				
2	ad wit	Completed	unk	unk												_
fand	12 should be filed withir h and Mental Hygiene. 7 is marked other than traumatic evant. the Ms	To Be	17. Father's Name (First, Mide	le, Last)				u	ınk	18. Mothe	er's Name	(First, Middle,	Maiden Sum	name)	unk	
lary	and N and N Is ma		19a. Informant's Name/Relati				19b. Maili	ng Address	(Street a	and Numbe	er or Rurai	Route Numbe	r, City or Tov	wn, State, Zip	Code)	
_ ≥	and and malth n 27	1	Caton Manor N	ursing	Home	an Di				Averu	e Ba	ltimore		21229	Chata	
altimore, Maryland	permit. Pages 1 and 2 should be filed withir Depa ment of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Ma once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 🖾 Othe	(Specify) i	oval from State n stat	e cei	metery, cre	osition (Nan matory or o	ther plac			ate	20c. Locatio	on - City or To	own, State	
Ball	permit Depa Import any in		21. Signature of Funeral Serv	Ce Licensee	Jeasan	nt	2:	2. Name an State Baltin	Ana Ana nore	tomy MD	Boar 2120	d 655 W	. Balt	imore	Street	
			23a. Part1. Enter the disease shock, or heart failure.	, or complication	ons that cause ause on each	ed the death. line.	Do not en	ter the mod	e of dyin	g, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
J.	Physician		Immediate Cause (Final disease or condition		ACUT	= 1	HE TO	RRHA	610	IN	TRAC	RAIVIAL	BLEE	ED	5 deep	
	/Medical Examiner		resulting in death)			s a conseque	ence of):					2-0/6/47/1			TANUART 15	
	LAdillilei	ب	Sequentially list conditions	b. —		RD10		PIRA	TORK		ARRE	ES1		-	2005	
	led sit	Examiner	Fequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	Dua 10 (01 a	3 a conseque	siloo oij.									
	be executed ician and burial-transil	xar	that initiated events resulting in death) Last	c	Due to (or a	s a conseque	ence of):									
8760,	icate be executed physician and s the burial-transit	cai		d												_
9	tificat ig phy as th	b														-
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate i within 24 hours after death. To tha Funaral Diractor: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		lf yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal of dea	death 3[⊒Ectopic pr ⊒ Other (sp						Date of delive Month	ery Day Year	
٩.	that I	y Ph	Part II. Other significant con	ditions contrib	uting to death	but not resul	ting in the u	ınderlying c	ause giv	en in Part I		23e. Did to	obacco use c	ontribute to t	he cause of death?	
ds.	puires n sigr	d by	G L10	3LAST=	ma.	MUL	TIFO	RME				1 🗆 Y	′es 2□No	o 3 ☐ Prot	pably 4 Unknown	
00	w reg	Completed										24a. Was		b. Were auto	psy findings available	
Re	The lav	mo										autop perfo 1 Yes	rmed?	death?	mpletion of cause of	
tal	an: T	BeC	25. Was case referred to me	tical						26. Place	of Death	(Check only o				
>	ysici iis cer direc	To B	examiner? 1 ☐ Yes 2 No	Hosp	oital: 1 ☐ Inpa	tient 2 🗆 E	R/Outpatie	nt 3 DC	Oth Oth	er: 4ENu	ursing Hon	ne 5 🗆 Resid	dence 6 🗆	Other (Specif	(v)	
0	ng Ph ter th neral		27. Manner of Death 1 Satural 5 ☐ Pe	nding 2	8a. Date of In (Month, E	jury Day Year)	28b. Time o Injury	of 2	8c. Injur Wor			28d. Describe h	now injury oc	curred		
.0	andir sath. or: Al	catic	2 Accident inv	estigation				М		Yes 2 🗌						-
Division of Vital Records,	afor Att after d Diract d in by t	Certification:		ermined 2	8e. Place of I building,	njury - At hor etc. <i>(Specify)</i>	ne, farm, si	reet, factory	, office		-	City or Tov		imber or Hura	al Route Number,	
	To the Hospital or Attanding Physician: The within 24 hours after death. To tha Funaral Diractor: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier Cert (Check only 2 Med	fying Physicie cal Examiner:	on: To the besion on the basis and manner	of examinati	rledge, dea on and/or it	th occurred nvestigation	at the tir , in my o	ne, date an pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)	_
	To th within To th comp	Me	29b. Signature and title of ce	tifier	\	M				e number	20			gned (Month,	Day, Year)	
			30. Name and address of per	son who comp	leted cause o	f death (Item	23a) (Type	D: 1)		0608			ANU	4129 1	7 XC05	_
_			NIVEDITA 1	SANIM	333	اانا دا	-WEN'S	AVE	NUE	130	TIM	NOME N	no al	1229.		
	Sta Regist	ate rar	31. Date filed (Month, Day, Y	ear)	32. Aegis	strar's Signat	ure K	arti								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Dav Year Sayer 0145AM 2005 January 17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Josephs Hospital Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Months Yrs Director 56 11-02-1948 Mary land 212-46-6398 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location •how 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-f ebov other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Md Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 534 Alleghany Ave 21204 Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) es 1 and 2 should be filed wood Health and Mental Hygien filem 27 is marked other th Painter Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **Blanch** Emmanual Sayer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is n 525 Yarmouth Road Towson, Maryland 21286 Steve Vance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö 01-29-2005 Woodlawn, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 22. Name and Address of Facility Wise Funeral Services 21. Signature of Fungral Service Licenses pode any i 700 S. Beechfield Ave Baltimore, Maryland 21229 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** a Myccardia Hour resulting in death) /Medical ue to (or as a consequence of): Examiner Cardio Vascular Disease 10 Years Arteriescleration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai as t the attending esn esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 TYes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page this certificate 2 No 1 Yes or Attending Physicien: rector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 No 1 🗌 Inpatient ě 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending To the river after death within 24 hours after death.

To the Funerel Director: After the further the 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 1866 completed cause of death (Item 2Ba) (Type, Print) 6 Trimble Hill CT. Lutherville, MI) 21093 Tel. 410 828- 8703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 State	autilianta of Dooth	ag. No. 2005 01553
			Ragistrar 1. Decedent's name (First, Middle, Last)	2. Date of Deat	
	Physici		ODE A TUSON -R	JANUAR	1 16 2005 0213 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Toym, or Location of Death	4c. County of Death
			3307 ELMORA AYE	BACT MORE	
	Funeral		5. Social Security Number 7.13 · \$\forall \text{7. Age (In yrs. last birthda)} \text{1V M 2 \subseteq F} \text{7. Age (In yrs. last birthda)} \text{Yrs.}	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,	9. Bithplace (State or Foreign
	Director		Usual Residence of Decedent	11.6	1766 MINKY LAND
	ow ow		10a. State 10b. County 10c. City, Jown or l	Location	10d. Inside City Limits
	Man a-f sh	tor	MD DAG	TIMORE	1 V Yes 2 □ No
	or 28)irec	10e. Street and Number		0g. Citizen of What Country?
	ath wi	by Funeral Director	3307 ELMORA AVE.	21213	U. S. F.
	tems	nue	11. Marita/Status 12. Was Decedent Ever in U.S. Armed Forces 13	B. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Caban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	oy F	1 Ves 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: BLACK
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show I.a M.cifeal Examinar must be notified at	ted	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b. Kind of Business/Industry
215	thin 7	ple	(Specify only highest grade completed) (Giv	ve kind of work done during most of working . DO NOT use retired)	EDUCATION
2	filed with Hygiene Ither thai	Completed	12th	300.03= 3.1	
nd	tal Hydra oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	Maiden Sumame)
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryian if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show item 27 is marked other than "natural", and item 27 is marked other than "natural be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mai 19b. Mai 19c. IVSDN, SL. FATHER 5011	4 / / / / / / / / / / / / / / / / / / /	ORE, MARYLAND 21204
ē	Heal Heal tem 2		20a Method of Disposition 20b. Place of Disp	position (Name of Date	20c. Location - City or Town, State
9	0 0		1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	rematory or other place)	ARBUTUS, MARYLAND
altimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licenses	22. Name and Address of Facility VAUGHN C.	CKEENE FUNERAL HOME
m	Depar Depar Impo any ir		Vacan Speech	1905 YORK ROAD BACTIM	ORE, MARYLAND 21212
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	Pnysician	J. 19	Immediate Cause (Final disease or condition	ial interction	Onset and Death MINUTES
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	D	2.00
	xamiiio:		Sequentially list conditions, if any, leading to immediate	പ് ന	¥!5,
	ted	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Mc00: tris	VIC
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	1 100	¥13.
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Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1□Liva birth 2□Fetal death 3	BEctopic pregnancy	23d. Date of delivery Month Day Year
	e dea the at ned fo	slci	in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown 1 □ Ves 2 □ No 9 □ ∪nknown	5 ☐ Other (specify)	Month Day Feat
P.0	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	pacco use contribute to the cause of death?
Records,	signe d be				os 2 □ No 3 □ Probably 4 XUnknown
20.	w requ	ete	7	24a. Was a	n 24b. Were autopsy findings available
Re	he lar e has age 2	Completed		autops perform	prior to completion of cause of death?
Vital	an: T tificat tor. pa	Be Co		1 ☐ Yes 2 26. Place of Death (Check only on	1 Yes 2 No
₹ <	Physician: this certific ral director.	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ient 3 DOA Other: 4 Nursing Home 5 Reside	nce 6 Other (Specify)
n of	ng Pt fter th neral	.:	27. Nanner of Leath 1 Natural 5 Pending 28a. Date of Injury 28b. Time Injury		w injury occurred
Sio	Attending It death. Sector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	
Division	l or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s	street, factory, office 28f. Location (St. City or Town	reet and Number or Rural Route Number, o, State)
Ц	spital ours a leral (Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and due to the co	ause(s) and manner as stated
	24 hos 24 hos e Fun etely	Medical	(Check only one) Addical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time, da	ate and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Me	29b. Signature and title of certifier	29c. License number 25	9d. Date signed (Month, Day, Year)
			Dheal Wylen MD	DZ10394	1-18-05
	Δ		3p Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	Balfomo
	-1		DUNGET. WEGEN, MD	USUA N. CHLARES SA	4411 21204
	Sta Regist		31. Date filed (Month, Day, Year) 32/ Registrar's Signature	doorle	•
	rtegist	ruii	JAN 2 4 2005 January At ,	a store and	

			For State Registrar	State of	f Maryland		artment o <i>rtificate</i>			Mental Hy	giene Reg. No. 2 (105	01551
	Physici		Decedent's Name (First, Middle,		Tamboli					2. Date of De Month Januar	ath Day	2005	3. Time of Death 5:00 PM
	/Medic Examir		4a. Facility Name (If not institution, Suburban Hospit		nber)			wn, or Location			4c. Coun	nt gome	
	Funeral Director				7. Age (In yrs. I. 72	ast birthday) Yrs.	If Under 1 Y Months D	ear If Und	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da June 13	th ly, Year) 1932	Cour	place (State or Foreign http) dia
	e Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montge	omery	10c. City	, Town or Lo	Bet	hesda					1
	1th with th 23a or 20 ust be m	ral Dire	10e. Street and Number 6409 Greentree				10f. Zip Co	2081				ed Sta	tes
9	DESIGNATION CE, INTERPLIATION Z I Z I 30-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pyglene. Important: If itam 27 is marked other than "natural" or items 23e or 28e-1 show any injury or other traumatic avant. The Medical Examinations be rediffied ut ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	Armed Fo	2 ⊠ No ⁄e	'	Was Deceden If Yes, specify 1☐ Yes 2፟፟፟፟፟፟፟፟፟፟፟፟	Cuban, Mex	ican, Puerto	pecify Yes or No o Rican, etc.)		ace - Americ lack, White, cify: As i	
,	Mary Iditio Z IZ 13-0030 od 2 should be filed within 72 hours att th and Mantal Hygtene. 27 is marked other than "natural" or traumatic avant, the Medical Exert traumatic avant, the Medical Exert	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		I-4or 5+)	(Give life. l	dent's Usual C kind of work of DO NOT use i memake	fone during n retired)	most of wor	king	16b. Kind of	Business/In	•
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	Daltimore, bermit. Pages 1 an Department of Heal mportant: If itam 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 4 ☐ Donation 5 ☐ Other (Sp		State Moi	lace of Dispo emetery, crer ntgome emator	esition (Name matory or othe TY ium, I	of r place)	Janu	Date 21,	20c. Location	-	own, State
3	Dairi. I permit. I Departm Importa any inju		21. Signature of Funeral Service I		M0019	80	Name and A	Address of Fa	hrev	Funeral Bethesd	Home/	Bethes	da-Chevy
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	/Medical Examiner	<u>-</u>	resulting in death) Sequentially list conditions,	Infil	(or as a consequence of the cons	ducta	l carc	inoma,	estr	ogen re	ceptor	negat	ive
50/1	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Wide	ly Meta: (or as a consequ	static							
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	on Ol ling Ph I. After th Vuneral	Certification; To	27. Manner of Death 1 Natural 5 Pendin 2 Accident investit 3 Suicide 6 Could	g 28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 28c	lnjury at Work? 1 ☐ Yes 2		28d. Describe	how injury occ	urred	al Route Number,
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ta	DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical					vestigation, in		death occu			e, and due t	o the cause(s)
	To To		> Michael a	. Wester				D52451			Januar	•	
4	5		30. Name and address of person Michael A. West	erman, M.	D. P.O	. Box	2316,	Kensin	gton,	Maryla	nd 2089	91	
	St Regist	ate trar	31. Date filed (Month, Day, Year) JAN 2 4	2005	Registrar's Signa	J. Ap	selv.						

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryla		artment of F rtificate of		Reg	ene 20	05 01	5
Dhusiai		1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day	3. Time o	
Physici /Medic		Ernest M. Towe					Januar:	y 11, 20	005 4:0.	5 PM
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Funeral Director		237-40-0474	7. Age (In yr	s. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1931	9. Birthplace (State Country) Virginia	or Fore
D .		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside C	ity Lim
arylan •how	5								1 🗆 Yes	
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within /2 hours atter death with the Maryland ene. Than "naturat", or iteme 23e or 28e-f ehow he Madical Examiner must be notified at	ai Dir	17944 Garden Lar	e #3		Tor. Zip Code	21740		US US	-	
9 4	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No-		- American Indian, White, etc.	
or its	3	1 ☐ Never Married 2 💢 Married	1 XYes 2 No If Yes, Give		1 ☐ Yes 2 🔯 No		10 1 110 111, 010.)		white	
- 1	1 by	3 Widowed 4 Divorced	Year or Dates:	1952	12 103 244110	opecny.		Зреспу.	WILLE	
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o d c	o Be	J. Fulton Towe				Lena	Westmore	land		
nd Men marke umatic	70	19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Maili	na Address (Street	and Number or Ri	ural Route Number,	City or Town. S	tate. Zin Code)	
th and 17 le trau		Ella Mae Towe/spe					Hagerstown			
Health tem 27 other tra		20a. Method of Disposition		. Place of Disp	osition (Name of			•	21740 lity or Town, State	
nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☒ Donation 5 ☐ Other (Specify,		cemetery, cre	matory`or other pla	ce)				
Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Ligens An Lhony D.	Pleasant	2	State Ana Baltimore	ess of Facility Atomy Boa	rd 655 W.	Baltim	ore Stree	t
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within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exem	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dear	h occurred at the ti ivestigation, in my	me, date and place	e, and due to the cau urred at the time, dat	ise(s) and mani e and place, an	ner as stated. nd due to the cause(s	s)
thin (Mec	29b. Signature and title of cert liero	and mariner stated.		29c. Licen	se number	29	d. Date signed	(Month, Day, Year)	
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Sta	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	Carle	1	1	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #19b PER FH G839 Gerzüligeste AMEND 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19, РМ JANUARY 2005 6:05 ROSE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Day, Year) 0CT.1,1903 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. Yrs. 101 MD 214-40-5432 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id 2 should be filed within 72 hours after death with the Marylan lib and Merial Hygiene. 27 Is marked other than "natural; or Items 23a or 28a-f show it traumatic event, tra Medical Exemine must be notified at 1 ☐ Yes 2 👿 No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1840 REISTERSTOWN ROAD 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER EDUCATION** permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any jury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TRALINS ZELDA JENNIE MOODMAN SAMUEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9307 BELLECK ROAD - BALTIMORE, MD 21234 DAVID TRALINS / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) BALTIMORE HEBREW CEM 01/21/2005 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician days acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has linector, page 2 s autopsy performed? 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Natural if or Attendin after death. | Director: Aft 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: / completely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and the of partifier 29c. License number 225205 completed cause of darth (Item 23a) (Type, Print) N. Charles St. Balto md

State Registrar JAN 2 4 2005

BMC 6701 N.
32. Egistrar's Signature

Maryland 21215-0036

68760.

Records.

Vital

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 19 2005 6:35 Р TAIRSTEIN JAN SAMUEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** REISTERSTOWN BALTIMORE FUTURE CARE CHERRYWOOD Hours Min. 8. Date of Birth Month Day, Year) OCT 2,1910 9. Birthplace (State or Foreign Country) ENGLAND If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Days Months 94 Yrs 212-30-8997 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Items 23a or 28e-f show the Medical Exercine must be notified at 1 V Yes 2 □ No Director N/A BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code **ENGLAND** 2500 W. BELVEDERE AVENUE #310 21215 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕱 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 🛣 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10College (1-4or 5+) COMPTROLLER BALTIMORE LUMBER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROSENBERG TAIRSTEIN KATE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 418 DOE MEADOW DRIVE - OWINGS MILLS, MD 21117 JILL SACKS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 01/21/2005 BALTIMORE, MD 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature - Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSENEROTTE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.O. I the hed 9 Unknown ģ sign**e**d b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 20 No 1 Yes 2 110 Hospital or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home a No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Mapner of Death Certification: After 5 Pending investigation Natural death. 1 TYes 2 No after deam 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 28395

State
Registrar

DHMH 17 Rev 1/2001

Name and address of pers

Year)

ASNEEM

72201

completed cause of death (Item 23a) (Type, Print)

32. Reistrar's Signature

KHHOVI

			1 - For State of Maryla	and / Department of Health and M Certificate of Death	dental Hygie	ne No.2005	01558
	Physici		1. Decedent's Name (First, Middle, Last) DELORES W	ILSON	2. Date of Death Month JANUARY	Day Year	3. Time of Death 3: 30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 1508 N- WOLT STREET	4b. City, Jown, or Location of Death	E .	4c. County of Death	1
	Funeral		5 Social Security Number 6 Sex 7 Age (In yo	s. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	nplace (State or Foreign
	Director		210 · 24 · 0083 1 · M 2 F 70	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	728 MA	RYLAND
	aryland show	7	10a. State 10b. County 10c. 0	City Town or Location			10d. Inside City Limits 1 ▼Yes 2 □ No
	h the M	Director	10e. Street and Number	BATIMORE 101. Zip Code	10g.	Citizen of What Cou	
	eath wit	Funerai D	1508 N. WOLF STRE		3 ecity Yes or No-	U.S.,	A.
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show "Iteal Examiner must be neithed at	by Fun	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cyban, Mexican, Puerto	Rican, etc.)	Black, Write	o, etc.
2-00	72 hour	eted t	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b	Kind of Business/I	ndustry
21215-0036	s withir jiene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DOMESTIC		DRIVA	TE
Maryland	o d a b	To Be C	17. Father's Name (First, Middle, Last) DANIEL CLARK	18. Mother's Name	e (First, Middle, Maid LA H	den Sumame)	
Man	d 2 sho th and t7 is m traum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run Jp 1508 N. WOLF St.	al Route Number, Ci		ip Code)
ore,	00-	i	1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory of other place)	Date 20c	Location - City or 1	
Baltimore,	그 든 윤 근		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee f	22. Name and Address of Facility VA	TAHAL C.	NGS MILLS GREENE	, MARYLAND FUNERAL HA
Ä	permit. Departimont import any inj		Vaugha Erene	4905 YORK ROA	O BALTI		1021212
	Physician		23a. Part1. Enter the disease, of complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) Due to (or as a conse	oquence of):			lyr
	_	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):			
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse	equence of):			
8760	ate be ex hysician the burial	icai	d				
Box 68	eath certifica attending pt for use as t	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg			23d. Date of deliv	verv
	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown			Month	Day Year
s, P.O	res that thighed by	by Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ord	w require been sig should b		Pulmonary luboli				bably 4 Mnknown
Vital Records,		Completed			24a. Was an autopsy performed	? death?	opsy findings available ompletion of cause of
Vita	sician: certific rector,	o Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2	0.0000000000000000000000000000000000000	h (Check only one)		
of	ding Phys th. : After this funeral di	\vdash	1 Yes 2 No 1 Inspired 1 Inpatient 2 2 27. Manner of Death 28a. Date of Injury (Month, Day Year)	LI EN Outpatient 3 L DOX 4 LINUISING NO	28d. Describe how in		ify)
Division	Attan deal ctor	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rui	ral Route Number,
D	oitat or A urs after ral Dirac lled in by		4 - nomiciae building, etc. (Spec		City or Town, Si		
	To the Hospitat or within 24 hours after To the Funeral Dira completely filled in b	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kill and manner stated.	nowledge, death occurred at the time, date and place, nation and/or investigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To tl withii To th	Ň	29b. Signature and title of certifier Suphu M. Smaldores	29c. License number (445783	29d.	Date signed (Month)	, Day, Year)
7	6				2		
	Sta	te.	Stephin G. Smildores 2021 I En 31. Date filed (Month, Day, Year) 32. # Sigistrar's Sig	em 23a) (Type, Print) wester Ad Ste 114 bel Air A nature A Apartle	na 21015		
	Registr	\$	31. Date filed (Month, Day, Year) 32. Agistrar's Sig	to Sperke		·	

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	Examir	ier	Good Samar 5. Social Security Number 6. Se	itan Hosp	last birthday)	(2	er 1 Year If Under 24 Hrs	8. Date of B	ay, Year,	4040	thplace (State or Fo	
ph.	Director wode	or	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo			Dec.	25,	1919 Þ	Vashingt 10d. Inside City Li 1 □ Yes 2₹	mits
	ith with the N 23e or 28e-f ust be notifi	Funeral Director	10e. Street and Number 4901 Rodgers D				ip Code 20735		Ţ	itizen of What Co		
920	within 72 hours after death with the Maryland ene. then "natural", or Itama 23e or 28e-f ahow ina Mulical Exercities crast be notified at	b	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes S∏ No If Yes, Give Year or Dates:	l.S. 13.		edent of Hispanic Origin? (Secify Cuban, Mexican, Puerl	pecify Yes or N to Rican, etc.)	10-	14. Race - Ame Brack, Whit Specify: Lac	e, etc.	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hyglene. If item 27 is marked other then "naturel", or Iteme 23e or 28e-f show or other traumatic event, ins Mudical Exercities in usine notified at	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 5th grade		(Give	kind of	sual Occupation work done during most of wo. use retired)	rking		(ind of Business)	/Industry	
Maryland 2	2 should be filed within and Mental Hygiene. ia markad othar than aumatic avant, ma Mi	To Be C	17. Father's Name (First, Middle, Last) Esau Redd				18. Mother's Nar	a Jenk:	n- Ce	lia Jen		
	1 and 2 sho Health and Ism 27 is m other traum		19a. Informant's Name/Relationship (7 Alice Wilhoit/ 20a. Method of Disposition	Daughter	Place of Dispe	osition (A		Date		o <i>r Town, Stat</i> e, 2 1arylan .ocation - City or		-
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Funeral Service Light	Kin	2	Mori 2. Name	al Park and Address of Facility C	natman	-Har	ris Fu	Marylan neral H	on
	Physician /Medical Examiner		23a. Part1. Enter the disease, or company shock or heardfailure. List only disease or condition resulting in death)	olications that caused the deal one cause on each line. a	th. Do not en		Reisterstor			imore,	Md2121 Approximate fnterval Between Onset and Deat	n
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09/89		Medicai	IF FEMALE:	d								
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Records, P	w requires that been signed b should be det	þ	Part II. Other significent conditions of Conges Ave	1)	-	underlying	g cause given in Part f.		tobacco Yes 2		o the cause of death robably 4 DUnkr	
	n: The law i ficate has b n, page 2 sh	e Completed	OF West and the Particular					1 Yes	opsy formed? 2 \(\) No	prior to death?	utopsy findings avai completion of cause 2 No	able of
on of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	of	28c. Injury at Work?		sidence	6 □Other (Spe	cify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, farm, st	M reet, fact	1 ☐ Yes 2 ☐ No	28f. Location City or Te	(Street a own, Stat	nd Number or Ru e)	ural Route Number,	_
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,	Within Comp	Σ	29b. Signature and title of certifier	enm\ Assoc	. Path		D35704			ate signed (Mont		
9) st	ate	30. Name and/address of person who Mo Ira P Lairsen 1 31. Date filed (Month, Day, Year)	completed cause of death (Ite 44	m 23a) (Type Mari La ature	Print)	D35704 osp 5601 La	ch Rav	en,	Blud L	814.2123	39
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	Examin Funeral	er	NORTHWEST HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	RANDALLSTOWN	8. Date of Birth AUG. 8,19	BALTIMOR	Enplace (State or Foreign
	Director		092-05-5711		AUG.8,191	13	MD 10d. Inside City Limits
	8a-feho	Director		SVILLE			1 ☐ Yes 2 💢 No
	n with th	ai Dir	10e. Street and Number 8911 REISTERSTOWN ROAD #104	10f. Zip Code 21208	Tog.	Citizen of What Co	USA
036	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked othar then "natural", or Itama 23a or 28a-f ehow many Injury or othar traumatic event, the Modreal Examinar must be indiffied at ance.	by Funerai	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	d within 72 ho piene. r then "natur the Medical	Completed	(Specify only highest grade completed) (Give life. C	ent's Usual Occupation kind of work done during most of workir IO NOT use retired)	ng	. Kind of Business/	•
	ld ba filed ental Hygis ked othar ic event, ii	To Be C	17. Father's Name (First, Middle, Last) JOSEPH FORE		(First, Middle, Maid		TLEMAN
Maryland	d 2 should ba it and Mental it and Mental it 7 le marked o traumatic eve	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address (Street and Number or Rura. REISTERSTOWN ROAL			
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or othar tr		20a. Method of Disposition 1 V Burial 2 Cremation 3 Removal from State 20b. Place of Disposicemetery, crem		ate 20c	Location - City or BALTIMO	Town, State
Baltii	parmit. F Departme Importar any Injur	7	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility SOL	LEVINSO	N & BROS.	, INC.
	Physician		23a. Party. Enter the disease of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
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	ate be executad nysician and he buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	Aspirat	cion Pneum	nonia	
8760,	cate be e physician the buria		d				
P.O. Box 6	that the death certificate be executed today by the attending physician and detached for use as the burial-transit	Physician/Medical		lEctopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
	quires that the n signed by th uld be detache	by	Part II. Other significant conditions contributing to death but not resulting in the un Dy G R KJ M LL M 1	iderlying cause given in Part I.	23e. Did tobacc		the cause of death?
Vital Records,	: The taw requires cate has been sign , page 2 should be	Completed	Dementa		24a. Was an autopsy performed 1 Yes 2	prior to death?	itopsy findings available completion of cause of 2 No
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ topatient 2 ☐ ER/Outpatient	26. Place of Death Other: 4 □ Nursing Hor	(Check only one) me 5 Residence	6 ☐Other (Spe	cify)
Division of	Attending Phyrdeath. sctor: After thi	ertification; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how it		
DIXI	tal or Attenders after death	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St		iral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death and manner: On the basis of examination and/or invalid manner stated.				
	To t with To t	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
_			30. Name and andress a person who a impleted cause of death flem 23a) (Type,	200 Old Cour,	+ rd; 13	altimen	70420p
	Sta Regist	ate rar	JAN 2 4 2005 31. Date filed (Month, Day, Year) JAN 2 4 2005 Security A Society	,			(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ZUU 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9, 12:30 PMM 2005 Ricardo Williams January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Medical Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 X M 2 □ F 50 557-82-6545 May 5, 1954 Director Usual Residence of Decedent 10a. State unk 10b. County 10d. Inside City Limits 10c. City. Town or Location unk ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at unk 1 ☐ Yes 2 ☐ No Director unk 101. Zip Code 10e. Street and Number 10g. Citizen of What Country? unk unk Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: black. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) unk College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th any njury or other traumatic event, tha page. unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Hospital Drive Cheverly, MD 20785
Date | 20c. Location - City or Town, State Prince George's Medical Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify) in state 21. Signature of Funeral Service L Anthony 22. Name and Address of Facility
State Anatomy B
Baltimore, MD Licensee D. Pleasant Anatomy Board 655 W. Baltimore Street ore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Houk moha /Medical Due to (or as a consequence of): Examiner Vein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, JOYRS RUG USE Physician/Medical NTRAVENOU IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2000 HEPATITIS Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an s certificate has t lirector, page 2 s autopsy performed? 1 ☐ Yes 2 No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 흔 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this : After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. i Director: d in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Director Completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifie D21428 JAN 9,2005 Leens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE'S HOSPITA GREEN MD HRINCE LINDA 31. Date filed (Month, D 32 Registrar's Signature Pay. State 2005 Registrar

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1		Please Type or Print in State of Maryla State Registrer 1. Decedent's Name (First, Middle, Last)	and / Depa		lealth and Me Death	•	ne 2005	0 5 6 2
Physicia /Medic Examin	al	William J. Zerhusen, Jr. 4a. Facility Name (If not institution, give street and number) Tohns Hopkins Rayview Medical	Contes	4b. City, Town, or	r Location of Death		4c. County of Death	6:23 PM
Funeral Director			rs. last birthday)			Date of Birth (Month, Day, Ye larch 24	N/A 9. Birth Cor. 1953 Mar	place (State or Foreigi intry) yland
n the Maryland r 28e-f ehow r cotiffed at	irector		City, Town or Lo			10g.	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Health and Mental Hygiene. The streams 23a or 28e-f ehow other treumstic event, the Marical Ever in a rimest be notified at	by Funeral Director	32 Powderock Place 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 DyDivorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		21236 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Dispanic Origin? (Specif an, Mexican, Puerto Rid Specify:	y Yes or No- can, etc.)	U.S.A. 14. Race - Ameri Black, White	
led within 72 hou lygiene. her than "nature nt, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired arpenter	during most of working		Carpenter	ŕ
should be and Mental is marked o	To Be	17. Father's Name (First, Middle, Last) William J. Zerhusen 19a. Informant's Name/Relationship (Type, Print) Mac. Elizaboth Zorbuson			18. Mother's Name (I Elizabeth and Number or Aural F ircle Unit	Noch	e ity or Town, State, Z	
permit. Pages 1 and 2 Department of Health Importent: If Item 27 any injury or other tre once.		1 Vaurial 2 Cremation 3 Removal from State	p. Place of Dispondentery, creed.	osition (Name of matory or other place ph Fuller 2. Name and Addre	Dat	9 200 5 ard J. R	Baltimore	Town, State , Maryland
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequentially list conditions.	Sequence of):					Approximate Interval Between Onset and Death
icate be executed physician and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution o						
at the death certificate by the attending physi tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of deli Month	very Day Year
requires that been signed should be de	Completed by P	Part II. Other significant conditions contributing to death but not Alcohol Abuse.	resulting in the u	underlying cause giv	en in Part I.	1 ☐ Yes 24a. Was an	2 □ No 3 ▼ Pro	topsy findings availabl
The ate h	To Be Com	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	2 □ ER/Outpatie	nt 3□ DOA Oth	26. Place of Death (ier: 4 ☐ Nursing Home		? death?	ompletion of cause of
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Certification; T	27. Manner of Death 1 Natural 2 \(\) Accident 3 \(\) Suicide 4 \(\) Homicide 28a. Date of Injury (Month, Day Year (Month) Month) Month (Month, Day Year (Month) Month) Month (Month, Day Year (Month) Month) Month (Month) Mon	it home, farm, si	M 1	y at 28 k? Yes 2 □ No	d. Describe how i	njury occurred t and Number or Ru	
the Hospitel or in 24 hours afte the Funerel Dis pletely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, dea	nvestigation, in my o	pinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	to the cause(s)
To with com	W	29b. Signature and little of certifier 30. Name and address of person who completed cause of death (h 00-) (T	Delen	5000	70		21, 2005
Sta Regist		JAN 2 4 2005		bein Ave	enve, Balt	imore,	מע צוצ	-47

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Zaied JANJUARY 18,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Mercy | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 6 0 4 6 2 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Country) **T**X Yrs. Director 42 215-88-6948 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 77 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exporter reset by inclining at Director XXYes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2221 East Baltimore Street 21231 U . S . A .

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nat any injury or other traumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) Computer Programer 12th grade 4yrs+ Social Security Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2221 East Baltimore St., Khalil Zaied-Husband Balto, Md 21231 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/20/05 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West nonpour 4300 Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or 1 jury Due to (or as a consequence of): Examiner ohysician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the s should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2/2/No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 🗆 No 1 🗌 Yes 1 Tes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ို 1 Yes 2€ No After thi funeral of 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death filled in by the t 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral C To the Hospitai 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 57 Paul David Rischero 31. Date filed (Month, Day, Year)

JAN 2 4 32. egistrar's Signature State 2005 Registrar

		1	State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 0 56
			1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia	an	MURIEL ELIZABETH BALLASES Month Day Year 7:10 P Month Day Year 7:10 P
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY 5 Serial Security Number 1 5 Sex 7 Age (In vrs. last hirthday) If Under 1 Year 1 Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign
	Funeral		5. Social Security North Days Hours Min. (Month, Day, Year)
	Director		264 30 1403 91 DEC 28 1913 ILLINOIS Usual Residence of Decedent
	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Ba-f s	ctor	MARYLAND ALLEGANY MIDLOTHIAN 1 □ Yes 2√√2 No
	or 28	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20111 OLD MIDLOTHIAN ROAD 21543 U.S.
	s 238	erai	ZUIII ULD MIDLUITIAN KOAD
ယ	be filed within 72 hours after death with the Maryland Hygiene. Id other then "neturel", or items 23a or 28a-f show ord other then "neturel", or items 20a on 28a-f show event, the Maryland Exam net must be notified at	by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
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/lar	2 should be and Mental is marked c	To B	CHARLES DEBENHAM HELEN READING
Maryland	12 sho h and 7 is mu traums		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES BALLASES / SON 20111 OLD MIDLOTHIAN ROAD, MIDLOTHIAN, MD 21543
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State compatery crematory or other place) 1/18/05
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) THE CUMBERLAND CREMATORY CUMBERLAND, Mill
alti	permit. Departn Importa eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET
113	<u>x</u> o.⊑ ■ a		SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532
Н			shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death) a
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Due to (or as a consequence of):
687	physicate sthe	edical	d.
Box (eath certific attending p I for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery Month Day Year
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Vital Records,	w require been si	Completed	Right Miss with Pulmenain metastasis 24a. Was an 24b. Were autopsy findings available
Re	he lav e has age 2	duc	Const 1 Cas autopsy performed? Carama C BRAIN Sundapped 1 Yes 2 DNo
tal		O	25. Was case referred to medical 26. Place of Death Check online
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n of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Unitry 28c. Injury at Work? Work?
Division		icati	2 Accident investigation 3 Suicide 6 Could not be determined each of the property of the could not be determined as a could not be d
Div	of or Attency after death	Certification:	4 Homicide determined determined building, etc. (Specify)
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	o the	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)
)	F 5 F 0		1) 25638 January 18, 2005
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
		1	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Regist	ate rar	JAN 2 4 2005 Region to franks
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland	Department of H Certificate of I			iene	5 01565
	Physici		1. Decedent's Name (First, Middle, Last) Linda Marie Beator				2. Date of Death Month January	n Day Year	3. Time of Peath 6:09 PM
	/Medic Examir		4a. Fecility Name (If not institution, give s University of Mary	treet and number)		Location of Death		4c. County of De.	
	Funeral Director		5. Social Security Number 037-24-8791 Usual Residence of Decedent	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March, 1	9. B 6, 1939 CC	nthplace (State or Foreign country) nnecticut
	e Maryland ta-f show	ctor	10a. State 10b. County Maryland Anne Art		own or Location	nnapolis			10d. Inside City Limits 1 X Yes 2 □ No
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "neturel", or Iteme 23a or 28a-1 show any injury or other traumatic event, it a Medical Examinar must be notified at once.	Completed by Funeral Director	10e. Street and Number 49 Pinkney Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade		10f. Zip Code 21401 13. Was Decedent of H If Yes, specify Cube 1 Yes 2 X No 6a. Decedent's Usual Occup (Give kind of work done) (Iffe. DO NOT use retired	Specify: Station during most of work	ecify Yes or No- Rican, etc.)	United St 14. Race - Arr Black, Wr Specify: 16b. Kind of Busines	ates nerican Indian, lite, etc. White
nd 212	e filed within al Hygiene. I other then went, the M	Be Comp	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Campus Di	rector	e (First, Middle, A	Ministr Maiden Sumame)	У
/aryla	2 should be and Menta is marked raumatic e	To E	Ivan William Fuqua 19a. Informant's Name/Relationship (Ty, Robert Richard Bea	ре, Print)	19b. Mailing Address (Street	and Number or Rur	al Route Number,		' '
	ages 1 and nt of Health t: if item 27		20a. Method of Disposition 1 Disposition 3 □R	20b. Plac	49 Pinkney S of Disposition (Name of etery, crematory or other place gate Memorial	20)	Date	20c. Location - City o	r Town, State
Baltimore,	permit. P. Departme Importent any injury once.		21. Signature of Eune/al Service Ligense		22. Name and Addre	ss of Facility JC	hn M. Ta	ylor Fune	s, Maryland ral Home,Inc. s, MD 21401
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Sepsis	Do not enter the mode of dyin				Approximate Interval Between Onset and Death
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.O. Box 68	that the death certific ed by the attending pl detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ※XXNo 9 ☐ Unknown	3c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 Ectopic pregnancy	/		23d. Date of d Month	elivery Day Year
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Vital R		Be Con	25. Was case referred to medical examiner?			26. Place of Deal	perform 1 Yes 2 th (Check only on	ned? death? ⊠No 1 □ Ye	s 2□ No
Division of V	ding .r After fune	၉	1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		VOutpatient 3☐ DOA Oth Bb. Time of Injury M 1☐	y at		nce 6 Other (Sp w injury occurred	ecity)
Divisi		Certification;	3 Suicide 6 Could not be determined	28e. Płace of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (St. City or Town	reet and Number or i i, State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edicai	29a. Certifier 1X Certifying Phy (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the tir n and/or investigation, in my o	me, date and place, prinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
	To the within 2. To the f	W	29b. Signature and title of certifier	H MO	29c. Licens AV417	6435R1303	_ 1	9d. Date signed (Moi January 3	- '
			30. Name and address of person who co			Baltimore	, Maryla	nd21201	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 6 20	32 Aegistrar's Signatur			•		

DHMH 16 Rev 6/95

Registrar

31. Dale Debustiano Barrera M. Registrer's Signeture Mem. Hosp Med Bldg Cumberland MD 21502

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

JAN 2 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2005 Anward /Medical John Henry Clarke,
4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL Heronico 546136UM If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Months Director 218-16-6475 August 11, 1925 Maryland Usual Residence of Decedent John H. Clauxe 218-16-6475
Baltimore, Maryland 21215-0036 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-1 show other treumetic event, the Madical Extendent or use to mailfied at 1 ☐ Yes 2 No Directo Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Riverview Park Drive 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. NYes 2 No 1943— Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No ģ Year or Dates: Specify: Specify: 3 Widowed 4 Divorced 1946 White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ing most of working Elementary/Secondary (0-12) College (1-4or 5+) Mathmatician -Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 should be fi and Mental h Henry Clarke, Sr. Ruth Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) p-rmit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree 2120 Riverview Park Drive, Poconoke City MD lace of Disposition (Name of 20c. Location - City of Town, State Sarah G. Clarke (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Salisbury Crematory January 11, 2005 Salisbury, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Holloway Melson Funeral Home P. A. 103 Linden Avenue, Pocomoke City, Maryland 21851 un or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 24 hRC /Medical Due to (or as a consequence of): Examiner. the Leukema Sequentially list conditions, any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conseque burial-transit Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2000 1 ☐ Yes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?

Yes 2 \(\sum \) No Be 26. Place of Death (Check only one) Hospital: Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

P.O. Box 68760

Hospitel or Attending Physicien: death.

Certification:

Medical

after death 24 hours a npletely within 2

1. H. 12+1 State

31. Date filed (Month, Day, Year) JAN 1

29b. Signature and title of certifier

Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

30. Name any address of person who completed cause of death (Item 23a) (Type, Print) STIVAS

29c. License number

560

Contriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

D36576 Ruessale De Salaly

1 ☐ Yes 2 ☐ No

*1*05

RONALD

5 Pending

investigation 6 Could not be determined

0 2005

32. Registrar's Signature

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

DHMH 16 Rev 6/95

Registrar

Anthony Pragotto 05-00343 RPD

		1	FOR	epartment of Health and I Certificate of Death	Mental Hygie Rag.	/ 11115 111569
	0		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	Physicia /Medic	al I	ANTHONY FRANCIS DRAGOTTO		1	14, 2005 O529 P M
	Examin	ar '	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
	Director		218-23-7688 Law 20 16 Value Residence of Decedent	rs.	JUNE 29	,1988 MARYLAND
	land		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Many -1 sh	ğ	MARYLAND PRINCE GEORGES BRAN	NDYWINE		1 ☐ Yes 2 No
	r 28a	Funeral Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	th with	a D	9601 DYSON ROAD	20613		U.S.A.
	ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	 Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland one. then "naturel", or litems 23a or 28a-f show the Medical Examera, ust be notified at		\times \text{\text{Wever Married}} 2 \subseteq \text{Married} \\ 3 \subseteq \text{Widowed} 4 \subseteq \text{Divorced} \\ \text{1 \subseteq Yes} \\ \text{Yes} \\	1 ☐ Yes 🎖 🛣 No Specify:		Specify: WHITE
21215-0036	hour turel	Completed by	45 Decederate Education 160	Decedent's Usual Occupation	16	b. Kind of Business/Industry
15	n "ne	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of wor life. DO NOT use retired)	king	
212	d with giena er tha	Com		UDENT		HIGH SCHOOL
P	ba filled tal Hygie d other avant, II	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	
yla	should ba nd Mental marked o umatic ava	ို	FRANCIS S. DRAGOTTO	JOAN Mo Mailing Address (Street and Number or Ru	ONIQUE E	
Maryland	12 sh h and 7 Is m traum		, , ,	100004V1+0-31 0004-000-1017 0-1004		
	pormit. Pagas 1 and 2 should ba filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiena. Important: If itam 27 is marked other than "naturel; or liems 23a or 28a-1 show any injury or other traumatic avant, it a Madical Extra net in its be mailfied at angle.	1	20a Method of Disposition 20b. Place of	Disposition (Name of		E , MD 206 L3. c. Location - City or Town, State
no	Pagas nent of int: If its iry or o		1 \(\Delta\) Burial 2 \(\text{Cremation} \) 3 \(\text{Hemoval from State} \)	r, crematory or other place)	10 OF 14	SERVED MEDVERSE
Baltimore,	permit. F Departme Importen any injur		21. Signature of Euneral Service Licensee MOO479	IEMORIAL GDNS. 1- 22. Name and Address of Facility		CONTRACTOR CONTRACTOR IN CONTRACTOR CONTRACT
ä	permii Depar Impor any ir once.		Michael O. Xy	RAYMOND FUNERAL	AND 20	646
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arres	Approximate Interval Between Onset and Death
	Pitysician	8 4	Immediate Cause (Final disease or condition	usories		Offset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of	f):		
	Lamine	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of	n·		
	ted	Examlner	cause (Disease or injury	·,·		
	execunand and al-tra	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of	f):		
68760,	cate be executed physician and the burial-transit	edical	d			
_			IF FEMALE:			
Вох	death certific e attending p id for use as	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	g o g	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
P.0	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
of Vital Records,	uires thai signed b	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
CO	> Q S	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re	Tha lav ate has page 2	omp			autopsy performe	ed? death?
ital	iician: Th certificate rector, pag	Φ	25. Was case referred to medical	26. Place of De	ath Check only one	
}	dis ys	To B	examiner? XXYes 2 □ No Hospital: 1 □ Inpatient 2X ER/Ou			ce 6 □Other (Specify)
ОП	ding Ph h. After th funeral		1 Natural 5 Pending (Month, Day Year)	ime of 28c. Injury at Work?	28d. Describe how	FCARIMPACT WITH CAN
Division	Attanding r death. actor: After by the fune	Certification:	- 1	TO M 1 Yes 2 No		et and Number or Rural Route Number,
Ξ	or All after of Dirac	ertif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	- 4	City or Town,	State) DIVQDBRAMYWINE HD
J	Hospital 24 hours a Funaral I tely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge	, death occurred at the time, date and place	e, and due to the cau	se(s) and manner as stated.
	na Hospital or Attand n 24 hours after death ne Funaral Diractor: /	edical	(Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.	Vor investigation, in my opinion, death occ	urred at the time, dat	e and place, and due to the cause(s)
	To tha Hosi within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	,		Mounte The Thill	O.C.M.E.	Ja	nuary 15, 2005
/	4		30. Name and address of person who completed cause of death (Item 23a)		moreo More	wland 21201
1	- 21			Penn Street, Balti	more, Mar	ATAUN TITAL
	St Regist	ate rar	31. Date filed (Month) ANY agr) 4 2005 32. Re Strar's Signature	Conti		

		-	For State Ragistrar	State of Maryland / Dep	partment of Health and ertificate of Death		2005	01570
	Dhuaisi		1. Decedent's Name (First, Middle, Last,		_	2. Date of Death Month	Day Year	3. Time of Death
1	Physicia /Medic	al -	Dale		Darrow	Januar-	1 16 2005	3.33 A W
	Examin	er	4a. Facility Name (If not institution, give	1 > 1	4b. City, Town, or Location of Deat		4c. County of Death	
			5. Social Security Number 6. Sec		v) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Baltimor	e lace (State or Foreign
	Funeral Director			M 2□F 66 Yrs.	Months Days Hours Min.	(Month, Day, Y	ear) Coun	yland
	P _		Usual Residence of Decedent					
	er death with the Marylan tems 23e or 28e-f show er man be notified at	2	Maryland Alleg	10c. City, Town or cany Cumber			10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Director	10e. Street and Number	darry Cumber	10f. Zip Code	100	2. Citizen of What Coun	
	with with be or		220 Sommerville	720	21502	100		uyr
	ler death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	specify Yes or No-	USA 14. Race - America	
9	after or Item	교	1 ☐ Never Married 2 ☐ Married	1 XYes 2 No	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2X No Specify:	to Rican, etc.)	Black, White, e	etc. hite
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15-	d within 72 ho jiene. r than "natul itie Modical	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)	rking	Sb. Kind of Business/Ind	lustry
12	filed withir Hygiene. other than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	geant	La	aw Enforce	ement
	Hyge H	BeC	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	uiden Sumame)	
lar	0 0 0	70 0	Charles Ralph D	arrow	Nettie	e MacMil	Lian	
Maryland			19a. Informant's Name/Relationship (T)		ailing Address (Street and Number or R			Code)
	s 1 and 2 of Health Item 27		Scott Darrow-Sc 20a. Method of Disposition	n 32	Oak St., Cumber	land, MI	21502	um Ctato
סב	of of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F		position (Name of rematory or other place) Jan		oc. Location - City or To	
altimore,			4 ☐ Donation 5 ☐ Other (Specify) 21. So ture of Funeral Service Licens		ap Veteran Cem 22. Name and Address of Facility	I	Clintston	e, MD
Ba	permit. Departm Importe any inju				Hafer Funeral S	Service,	PA	
			23a. Part1. Enter the disease, or comp	ications that caused the death. Do not ne cause on each line.	anter the mode of dying, such a Lardia	W. Waspiratory a. Was	ale, MD 2	ate Interval Between
	Physician		Immediate Cause (Final disease or condition	by potensi	a			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):		0:1		J MINNOCKS
P	Examiner		Sequentially list conditions,	D.	rgan system	~ Foilu	13e :	2 weeks
2	ed sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	4			3
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):				2 meets
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dlcal E		d				
9	rtificat ng phy as th	Medi	IS SCHALE.					
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ⊟Ectopic pregnancy		23d. Date of delive Month	ory Day Year
O.	the at	slcl	1 Yes 2 No	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Width	Day real
Δ.	that the dead by the detached			ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
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CO	w require been si should b	lete				24a. Was an	24b. Were autor	psy findings available
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Vital		0)	25. Was case referred to medical		26. Place of De	ath (Check only one)		20 No
Į V	99 (// =	To B	examiner? 1 ☐ Yes 2:5 No	Hospital: 1 Inpatient 2 ER/Outpat	tient 3 DOA Other: 4 Nursing	Home 5 Residen	ce 6 Other (Specify	1)
n 0	iding Phy th. After this funeral o		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injur	y Work?	28d. Describe how	injury occurred	
sio	or Attending ifter death. Director: After in by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	20. 20	M 1 Yes 2 No	004 1 104 104		
Division of	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Rura State)	i Houte Number,
	ours cours and perel		29a. Certifier 1 Certifying Phy	rsician: To the best of my knowledge, de	eath occurred at the time, date and place	e, and due to the cau	use(s) and manner as st	ated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Madical Exam one)	inar: On the basis of examination and/or	investigation in my opinion death occ	urrad at the time, dat	a and place, and due to	the equec(e)
	To the To the comp	M	29b. Signature and title of certifier	2 *	29c. License number	290	d. Date signed (Month, I	Day, Year)
	1		· Matter f. Co	l.	KES-000	71	anuary 11	2, 2005
	1			ompleted cause of death (Item 23a) (Typ	pe, Print)	no + C	410	
			Matthew J.	Weiss 600	Morth wells St	JEE 1 /	southerner e	Mary buck 2138
	Sta Regist		JAN 2 4 2005	Stephen It by	29c. License number RES-000 De, Print) North Wolfe St			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 24a per verbal mr 9839 1-21-05 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month January **Physician** Ray Weller Eddy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Yrs. 80 Director September 27,1924 215-26-1985 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other traumatic event, the Medical Exercities reserved. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Funeral Director MD Washington Hancock 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 21750 7626 Eddy Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Truck Assembly Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Brooks Eddy Kathryn Reba Weller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theabelle E. Eddy/Wife 7626 Eddy Drive Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 01/14/05 Hagerstown, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, F.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -Uno CANCEY /Medical Due to (or 4 a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner DIVISION OF VITAL RECOFUS, P.O. BOX 68760, attending physician and for use as the burial-transit Cause (Disease or i that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 10 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 SaNatural 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2323 /12/05 Day 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JAN 2 1 2005 126 () pa 32. Registrar's Signature State leven & pole Registrar

		1	For State Registrar	State	of Marylai		artment of H rtificate of L		Mental Hygi	ene 00	5 0	01572	
Phys	sicia:	n	Decedent's Name (First, Middle,	last) BERTHA	GRACE	FLATT			2. Date of Death January	-	Vana	3. Time of Death 7-25 PM	
Exar			4a. Facility Name (If not institution, 9 6625 Keysville		umber)		4b. City, Town, or Keymar	Location of Death	1	4c. County of	of Death		
Funer Direct		4	5. Social Security Number 219–12–5297	Sex 1□M 2∏xF		. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 29	Year) , 1914	9. Birthplac Country Kansas	ce (State or Foreign S	
ryland show			Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d	I. Inside City Limits	
he Ma 28a-f s		Director	Maryland Carr	coll		Keym	10f. Zip Code		10	g. Citizen of W	/hat Causta	1 ☐ Yes 2 ☐ No	
3a or	i		6625 Keysville Road				21757			USA	mat Country		
rs after deatl		by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed F	27 No	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black	- American k, White, etc White	C.	
iarylania 21215-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked other than "natural; or items 23a or 28a-f show aumatic event, the Marcial Estim arrings be notified a		Completed	(Specify only highest grade completed) (Give life.				kind of work done during most of working DO NOT use retired)			Sb. Kind of Business/Industry retail sales			
filed w Hygier other ti			17. Father's Name (First, Middle, La	ıst)		OII	ice worke		ne (First, Middle, M			>	
VISITO nuld be fill Mental Hy arkad oth	1	To Be	Amos Frank Linscott					Grace Beatrice Hanson					
Mary 12 sho h and l 7 is mu			19a. Informant's Name/Relationship Mary Motley / d						ral Route Number, Keymar, M			ode)	
s 1 and f Healt itam 2	1		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place			1D 2175 0c. Location - 0		n, State	
DESILLINO Definit. Pages Department of mportant: If it is not injury or			1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	B □Removal from cify)	State Sn	nithsbu	rg Cremat	ory 01/2		mithsbu		1D	
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			23a. P. 1. Enter the disease, or cosh ck, or heart failure. List or	omplications that							A	approximate nterval Between	
Physicia	_		Immediate Cause (Final disease or condition resulting in death)	_a. C	OPD						ĉ	Onset and Death	
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ob fou, icate be executed physician and s the burial-transit		dicai		d								_	
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The lay ate has page 2		ပို	DEMENTIA							HNO 1			
8 0 T		o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{PNo} \)	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	00	ath (Check only one lome 5 Nesider		er (Specify)		
		ou:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Dat	e of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injun Wor	y at k?	28d. Describe how				
DIVISION I or Attending after death. Diractor: After I in by the funer		ertification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location (Stre- City or Town, S			et and Number or Rural Route Number, State)						
, DIVISION To the Hospital or Attend within 24 hours after death to the Funaral Directors: completely filled in by the		edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To II within Y		¥	29b. Signature and title of equifier	the	1 /	n. B ,	29c. Licens			d. Date signed		•	
(2 ⁰			30. Name and address of person w	the completed ca	use of death (Ite	om 23a) (Type, 417 €	BALT	ST#	D, TANE	= Y TO W	N M	5 D 21787	
	Stat istra		31. Date filed (Month, Day, Year)	32.	Regionar's Sign								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State AMENDED 2, 1/7/05, LDB, DOR Certificate of Death Reg. No. 2. Date of Death JAN . 3, 2005 1. Decedent's Name (First, Middle, Last) Month **Physician** FLowers 40 AM -RANCES 2065 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Cambridge 16 Bellevue Avenue 8. Date of Birth June 9, 1925 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1□M 200F Mary land 79 Yrs 218-16-8039 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f ehow item 27 is marked other than "natural", or Items 23a or 28a-f ebov other traumatic event, the Medical Examinan must be multified at 1 TYes 2 PMG Maryland Dorchester Cambridge Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 USA 16 Bellevue Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Deportment of Health and Mental Hygiene important: if item 27 is marked other that any injury or other traumatic event, treat once. Board of Education Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Blanche Seward William H. Leonard, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Bellevue Ave., Cambridge, MD 21613 Dr. Thomas A. Flowers/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1/5/2005 Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Rant. Enter the disease, or complications the shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition 10 mos **Physician** lunc /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed tran that initiated events resulting in death) Last and Due to (or as a consequence of) burial-t Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) □Yes 25No detached 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? ension 24a. Was an autopsy performed? certificate has page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 302 CUlling en

State Registrar 31. Date filed (Month, Day Year

rar's Signature

		1	State Registrar Amend Ite	State of Ma na 26 per Ve	aryland rb.,G	1 / Depa 843-0 /	rtment of F	lealth and i B eath	Mental Hyg	giene	005	01574
		_	Decedent's Name (First, Middle,	Last)					2. Date of Dea		Year	3. Time of Death
	Physicia /Medic	_	Patricia	Hayder	Λ.				01	02	05	12:18AM
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of Death	1		unty of Death	1.1
			5. Social Security Number	5. Sex 7. Ag	e (In yrs. la	st hirthday)	If Under 1 Year	POIS If Under 24 Hrs.	8. Date of Birt		ne A	ace (State or Foreign
	Funeral Director		218 28 4718		30	Yrs.	Months Days	Hours Min.	10/07/	y, Year)	Coun	land
			Usual Residence of Decedent	A	T							
	anylan show		10a. State 10b. County			Town or Loc					10	0d. Inside City Limits 1 ☐ Yes 2 XNo
	Ne Mark	Director	MD Anne A	runaeı	AIII	apolis	10f. Zip Code			10g Citizen	of What Coun	
	with the man	급	16 Decatur Aven	ne			21403			USA	or what cours	
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show tha Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No		Race - Americ	
9	or iter	고	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 Tes 2 Armed Forces?			Yes, specify Cuba	an, Mexican, Puert Specify:	o Hican, etc.)		Black, White, e ec <i>ify:</i> Ta Th i	
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/lar	2 should be filed withir and Mental Hygiene. is markad other than raumatic event, the M.	ToE	John Doxey Park	inson				Ruth B	aynes 			
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	1 and 1eaith am 27 thar tr	1	John D. Hayden 20a. Method of Disposition	(son)	20b. Pla		ODINSON sition (Name of	Place Co	Date Sev		on - City or To	
סב	Pages nent of H int: If its iry or of		1 Burial 2 □ Cremation		ce	metery, cren	natory or other place	ery 1/4/			nsville	
Baltimore,		-	' 4 ☐ Donation 5 ☐ Other (Sc 21. Signature of Fullera Service L		1	22	Name and Addre	ss of Facility				
Ba	permit. Departr Imports any inje		N.W.	0		Ac	lvent Fur	eral and	Cremati	on Se	rvices	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused may one cause on each li	d the death	. Do not ent	or the mode of dyir	ng, such as cardia	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		mor	ria.						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		ence of):	. ()	_ 1		(>		
	LXummor	_	Sequentially list conditions,	b. Chron	a consequ	ence of):	tructi	ve pul	monor	/ di	sea se	
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9	entifica ing pt e as ti		IF FEMALE:	00.11								
Вох	death certifi e attending I id for use as	Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)	+		23d.	Date of delive Month	ry Day Year
Ö	y the d	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	11 111/10 01 00	1	Cirio (Specify)					
Δ.	wrequires that the deben signed by the should be detached	y Pr	Part II. Other significant conditio	ns contributing to death t	out not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
rds	quire en sig uld b	ed b	Cardiomyo	sathy					1)50	(es 2□N	o 3 ☐ Prob	ably 4 Unknown
Vital Records,	2 5 8	plet	·	/					24a. Was		prior to cor	psy findings available inpletion of cause of
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	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medical		Physicien: To the best examiner: On the basis of and manner st	of examinat							
LI .	To the within 2 To the comple	Me	29b. Signature and title of certifier	Ph			29c. Licens				gned (Month,	
			> Stephen (Slex, m			D58	3510		011	02/0	5
			30. Name and address of person	who completed cause of	death (Item	23a) (Туре, М (Print)					
	Sta Regist		31. Date filed (Month, Day, Year)	4 2005 32. F gist	rar's Signat	ture	book					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Month **Physician** Year Mary Katherine Holden 1130 January 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner EASTON MEMORIAL HOSPITAL TALBUT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 257 Days Hours Min Yrs. 215-10-6067 Director 8, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 Nes 2 No Directo Talbot Maryland Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Port St., Apt. 109 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) 12 College (1-4or 5+) Fashion Artist Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ebenezer Willis Ward Hoyt Nell Donlan 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 20840 Elfin Forest Rd., Dr. Matthew G. Holden/Son Escondido, CA 92029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Scremation 3 □ Removal from State ō permit. Page Department of Importent: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cemetery 1/14/2005 Easton, Maryland 21. Signature of Funeral/Service Licensee ²² Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 once. 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION CARDIAL **Physician** WEEK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţ in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 1 ☐ Yes 2 X No 2 No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 5 Residence 6 ☐Other (Specify) this hours after death.

Inerel Director: After this y tilled in by the tuneral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide ō Hospitei within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number thoun D00 288 08 01104105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Staté Registrar 31. Date filed (Month, Day, Year) JAN 0 6

Dr. Florin Rusu, 219 S. Washington St., Easton, MD 21601

		1 - For State Registrar	State of M			artme		ealth a		lental Hy	giene Reg. No.	2001	0157
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, L Frances 4a. Facility Name (If not institution, gr SHADY GROVE AD	ve street and number					Location o	of Death	2. Date of De Month Jan	Day Cl	County of Dea	th (6:55 A M
Funeral Director		Social Security Number 6.			last birthday) Yrs.	1	CKVI. er 1 Year s Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir JUNE		930 9. Bi	MERY hthplace (State or Foreign ountry) VA
Within 72 hours after death with the Maryland within 72 hours after death with the Maryland sne. The markers!, or iteme 23s. or 28s-1 show than "retural; or iteme 23s. or 28s-1 show the Maryleal Examples may be mylling at	ector	10a. State 10b. County MD MONTGO	MERY	10c. Ci	ty, Town or Lo	VIL	LE lip Code				10g Citi	zen of What C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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hat hat deta	þ	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.					o the cause of death? robably 4 \(\square\square\square\) Tunknown
The ate h	Completed											24b. Were a prior to death?	utopsy findings available completion of cause of s 22:No
Attending Physician: Trideath. In death. In the funeral director, pa	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of In (Month, D		ER/Outpatier 28b. Time of Injury		28c. Injury Work	er: 4 □ Nu	rsing Hon	(Check only one 5 Residence Residenc	dence 6		acify)
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To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical Example 29b. Signature and title of certifier	Physician: To the bes aminer: On the basis and manner s	of examina	owledge, death ation and/or in	vestigatio	d at the tim in, in my op 9c. License	pinion, deat	d place, a h occurre	ed at the time,	date and	place, and du	s stated. e to the cause(s) th, Day, Year)
To Too		Christma 30. Name and address of person who	Leportu		M []	> 1	>6	154	19		Ja		8 2005
Sta Registr	-	CHRISTINE L 31. Date filed (Month, Day, Year)	EPOUTRE,		9901 1		CAL	CENT	ER_I	OR ROC	CKVI	LLE, N	1D 20850

	-	For State Registrar		-	epartment of F Certificate of			g. No.2005	0157
		1. Decedent's Name (First, Middle	, Last)			- 2	2. Date of Death		3. Time of Death
hysiciar? Medica/		Amos Jones				J	anuary	2, 2005 Year	3:10 P
amine	-	4a. Facility Name (If not institution	give street and number)		4b. City, Town, o	or Location of Death		4c. County of De	ath
		817 Camp Meade	Road		Linthicu	ım		Anne Aru	ndel
ral or		5. Social Security Number 579–40–5330	6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	76 Y	nday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day,) 1/12/19	9. B 28 F10	irthplace (State or Foreig Country) rida
ŝ		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Once. To Be Completed by Elizarel Director	5	Marral and Dada							1 X Yes 2 □ No
0	\sim	Maryland Prince	Georges	Landove	10f. Zip Code		100	g. Citizen of What C	Country?
2	5	4100 Beall Stre	.		20784		1	USA	odinay (
040	by Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spec		14. Race - Am	nerican Indian,
ů	בֿ	1 ☐ Never Married 2 🔯 Marri	Armed Forces? ed 1 ∑Yes 2 □ No If Yes, Give	5			can, etc.)	Black, Wh	ite, etc.
Š	2	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	51-'53	1 ☐ Yes 2 🔀 No	Specify:		Specify: B1	.ack
100	Completed	15. Decedent (Specify only highes	's Education	16a. I	Decedent's Usual Occup	pation	1 16	6b. Kind of Busines	s/Industry
700	ď	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Give kind of work done life. DO NOT use retire	dding most of working		nited Sta	
Š	5	12		Off	-Set Press			ederal Go	vernment
9	ge	17. Father's Name (First, Middle, I	•		<i>*</i>	18. Mother's Name (First, Middle, Ma	aiden Sumame)	
5	0	Clarence Jones,				Birdsie P			
		19a. Informant's Name/Relationsh			Mailing Address (Street				
	1	Rena E. Jones/	Wite		00 Beall St				
		20a. Method of Disposition 1 □ Burial 2 ☆Cremation	3 □Removal from State	cemetery	Disposition (Name of , crematory or other plan			Oc. Location - City of	r Town, State
		'4 □ Donation 5 □ Other (Sp	pecify)	Huntt	Crematory	01/04/		aldorf, M	
		21. Signature of Funeral Service 1	icensoe			ess of Facility Robe			
		177			The second second	apolis Road			20715
ı		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to only one cause on each line	the death. Do no 3.	ot enter the mode of dyir	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between
		Immediate Cause (Final disease or condition	Anorexia						Onset and Death 2 months
		resulting in death)	Due to (or as a	consequence o	f):			14	/st 55.00
		Sequentially list conditions,	b. Neoplasm						2 months
	=	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Present or multy) that initiated events	Due to (or as a	consequence o):				
Von	Examiner	that initiated events resulting in death) Last	c	consequence o	η.				
1	Cal				·/-				
			d						
/AA	/Me	IF FEMALE:	23c. If yes, outcome o	f pregnancy				004 5 (4	-1'
relation	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date of de Month	Day Year
40	=	Part II. Other significant conditio	ns contributing to death but	not resulting in	the underlying cause giv	ven in Part I	23a. Did toba	icco use contribute:	to the cause of death?
					, ,		1 ☐ Yes	2 □ No 3 ₹□ F	Probably 4 Unknown
910	ele								
2	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
	0						1 ☐ Yes 2		s 2 No
		25. Was case referred to medical examiner?	Hospital:		011	26. Place of Death /			
d	e u	1 ☐ Yes 2 汉 No	1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Out	Datient 3 DOA				ecity) HOSPICE
To Bo	0 26	- 21			ury Wor	rk?]Yes 2 □No	d. Describe how	/ Injury occurred	
TO Bo	0 26	27. Manner of Death 1 XiNatural 5 □ Pending					f Longtion /Stra	and Alumbas as I	Tural Cauta Number
To Ba	0 26	27. Manner of Death 1 X Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation of be	At home for			City as Tarre	State)	Rural Route Number,
To Bo	0 26	27. Manner of Death 1 X Natural 5 Pending 2 Accident investig	ation of be	y - At home, fari (Specify)	m, street, factory, office	20	City or Town,		
Cortification. To Bo	Certification: 10 Be	27. Manner of Death 1 Xi Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 27. Manner of Death 5 Pending investig determi	ation of be and 28e. Place of Injurbuilding, etc. g Physician: To the best of Exeminer: On the basis of a	(Specify) my knowledge, examination and	death occurred at the tir	me date and place an	d due to the cau	use(s) and manner a e and place, and du	is stated.
Cartification: To Ba	0 26	27. Manner of Death 1 Xi Natural 2 Accident 5 Pending investig 3 Suicide 6 Could in determined 29a. Certifler (Check only one)	g Physician: To the best of eand manner stati	(Specify) my knowledge, examination and	death occurred at the tir or investigation, in my c	me, date and place, an opinion, death occurred	d due to the cau at the time, date	e and place, and du	e to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11cm 5 per .fh .e841 3-22-05 vt

S			For State Registrar	State of Ma		partment of F ertificate of			giene Rag. No.	
	Physici /Medic		Deborah Anne	Jackson				2. Date of De Month Januar	Day Year	3. Time of Death 7 8
	Examir		4a. Facility Name (If not institution, g				r Location of Deat Burnie		4c. County of De	Arundel
	Funeral Director		5. Soliaty September 1975 6 217-46-3497 Usual Residence of Decedent	.Sex 7. Age 1 ☐ M 2 🖾 F	(In yrs. last birthda 51 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			irthplace (State or Foreign Country) Maryland
	r 28a-f show	or	10a. State 10b. County MD Anne A	rundel	10c. City, Town or Severna					10d. tnside City Limits 1 ☐ Yes 2 ☒ No
	th with the N 23s or 28s- ust be notifi	Funeral Director	10e. Street and Number 156 Boone Trail			10f. Zip Code	1146		10g. Citizen of What C	Country?
936	after dea or Items	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1		3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No to Rican, etc.)	- 14. Race - Am Btack, Wh	
Maryland 21215-0036	na na	Completed	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	(Giv	vedent's Usual Occup ve kind of work done . DO NOT use retire HOMEMA	during most of wo d)	rking	16b. Kind of Busines	
land	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than other treumatic event, Ite M	To Be C	17. Father's Name (First, Middle, La Frederick C. Qu					me (First, Middle, Dara A. S	Maiden Sumame) Siegman	
	and 2 should be to salth and Mental In 27 is marked of intermetic even		19a. Informant's Name/Relationship Robert Lawrence						er, City or Town, State, Cnie, MD 21	, ,
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 1 <u>20029.</u>		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 1 ☐ Dopation 9 ☐ Other (Spe	□Removal from State	cemetery, cr	position (Name of rematory or other pla Crematory	Juli	uary 5,	20c. Location - City of Baltimore	
Balti	permit. Departr Importe any inji		21. Sonature of Janeral Sovice Uto	me-		22. Name and Addre Barranco & 495 Gov. E	Ritchie H	lwy. Set	zerna Park,	Funeral Home MD 21146
	Physician /Medical Examiner	iner	23a. Pany. Enter the disease, or or spock, or heart failure. List or timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. CONTACT Due to (or as a				HEAD		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
P.O. Box 6	law requires that the death certificate been signed by the attending (2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Inknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 10 ☐ Unknown	2 Fetal death 3	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of di Month	elivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to death bu	t not resulting in the	underlying cause gn	ven in Part I.		obacco use contribute (es 2 2 N o 3 🗆 F	to the cause of death? Probably 4 Unknown
al Reco	The ate h page	Completed						1 Yes	prior to death? 2 No 1 X Ye	
Division of Vital Records,	ng Phys (fter this uneral di	atlon; To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injung (Month, Day For 1/3/0	Year) Injury	of 28c. Inju	ner: 4 🗆 Nursing H			ecity) at scene
Divis	를 를 들	Certification:	3 Sucide 6 ☐ Could no 4 ☐ Homicide determin	building, etc.	G LOT	street, factory, office		1940 CA	AIN HWY, GL	EN BURNIE, HP
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only one) Medical Ex	Physician: To the best one miner: On the basis of and manner state.	examination and/or	investigation, in my	pinion, death occu	urred at the time,	date and place, and du	ue to the cause(s)
	with To Con	-	29b. Signature and title of certifier	-		29c. Licens			29d. Date signed <i>(Mor</i> January 4	, 2005
				WBIO, MD		e, Print) 111 Pe	nn Stree	t Baltim	ore MD 2120	01
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 6	2005 32. Jogistra	r's Signature	growth.				

			For State Registrar		State of N	/laryland / [Departme <i>Certifica</i>				giene Reg. No.20	05	01579
	Obveisi		Decedent's Name (Fin	st, Middle, Last)			-			2. Date of Dea		Year	3. Time of Death
	Physici /Media	cal	Donald	M.		Jenkii				JANUA	RY 12, 2	2005	17:20 M
	Examir	er	4a. Facility Name (If not			r)			Location of Dea	th	4c. County		
144	. Funeral		MEMORIAL I 5. Social Security Number	er 6. Sex	7. /	Age (In yrs. last bir	thday) If Und	BERLA er 1 Year	If Under 24 Hrs		ALLE(9. Birthp	lace (State or Foreign
	Director		214-32-359	0 11]M 2□F	65	Yrs. Months	Days	Hours Min	Dec 20	, 1939	V	WV.
	rland ow		Usual Residence of Dec 10a. State 10t	. County		10c. City, Town	n or Location					1	0d. Inside City Limits
	e-f sh	ctor	MD	Allegany	/	Cı	ımberla	nd					1√ Yes 2 No
	o 72 hours after death with the Maryland "natural", or Iteme 23s or 28e-1 show salical Examiner must be notified at	Director	10e. Street and Number				10f. Z	ip Code	4500		10g. Citizen of W		try?
	leath v	Funerai	220 Somer		NUE 12. Was Deceder	nt Ever in U.S.	13 Was Dec		21502	Specify Yes or No-	US 14 Bace		an Indian,
9	after dea or Iteme	Fun	1 Never Married		Armed Forces 1 Yes 2 If Yes, Give	5?	If Yes, sp			Specify Yes or No- to Rican, etc.)		k, White,	etc.
003	ural',	d by	3X Widowed 4 □		Year or Dates	1957-59			Specify:			white	
15	c *_ @	ojete	(Specify or	Decedent's Edu	completed)		Decedent's Us (Give kind of w life. DO NOT	ual Occupa ork done di use retired)	ition luring most of wo)	orking	16b. Kind of Bu	siness/Ind	lustry
212	be filed within tal Hygiene. d other then "	Completed	Elementary/Secondary	y (0-12)	College (1-4o	Lab	orer				Cumb. C	oncr	ete
pul		Be	17. Father's Name (First		nkino					me (First, Middle,		,	ino
Maryland 21215-0036	d 2 should be th and Mental 7 Is marked o treumatic eve	၉	William N 19a. Informant's Name/			19h	Mailing Address	s (Street a		/irginia (M ural Route Numbe			
	d2 s h ar 7 is treu		Donald Jer		son	1	1311 Di	usty L	ane NE	Cumb	erland	MĎ	21502
Baltimore,	L L L		20a. Method of Dispositi 1 XBurial 2 ☐ Cro 1 4 ☐ Donation 5 ☐	emation 3 □R	emoval from Stat	cemeter	Disposition (Na y, crematory or emorial C	other place		Date 1/15/2005	20c. Location - Cumbe		wn, State
Baltir	permit. Pag Department Importent: I any injury o		21. Signature of Funeral) An 1	111			ser Facility Funeral H	lome, PA	Cumbo	nana	1010
			23a Part 1. Enter the dis	sease, or compli	cations that cause	ed the death. Do r				e: Cumber		21502	Approximate
	Physician		shock, or heart fail Immediate Cause (Final disease or condition	ure. List only or	e cause on each	ine.				PULMON			Interval Between
	/Medical Examiner		resulting in death)	C a	Due to (or a	s a consequence	of):		ULIVE	1 DLMUN	INKY D.	NAME OF THE PARTY	715.
L	×.	10	Sequentially list condition	ns, b	Due to (or a	s a consequence of	of).						
	uted d ansit	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	1	540 10 (01 0		51).						
oʻ	be executed sician and burial-transit		resulting in death) Last	· ·	Due to (or a	s a consequence of	of):						
8760,	cate be ex physician the buria	dicai											
9	death certifica attending ph I for use as th	0	IF FEMALE:	. 2	3c. If yes, outcom	e of pregnancy					and Dave		
. Box	death le atter	Physician/M	in the past 12 month 1 ☐ Yes 2 ☐ No	dirant l	1□Live birth 4□Pregnant	2 Fetal death at time of death	3 □Ectopic p 5 □ Other (s				23d. Date Mon		ry Day Year
P.0	at the de by the a stached	hys	9 Unknown		9□ Unknown								1000
	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by	Part II. Other significant		tributing to death		the underlying	cause giver	n in Part I.	23e. Did to	_		e cause of death?
Records,	w requir been si should	Completed	THE THE	1	12/10	014				24a. Was a			
Re	The law ate has b page 2 s	ошо								autop: perfor	med? de	ior to comeath?	psy findings available apletion of cause of
Vital		Be C	25. Was case referred to examiner?	medical					26. Place of De	1 ☐ Yes ath Check onl or		Yes	2 2 No
of V	dis y	၉	1 ☐ Yes 2 ☑ No	Н	ospital: 1 Ampai				4 Nursing F	dome 5 ☐ Reside	ence 6 Othe	r (Specify)
ouo	ling After fune	tlon:		Pending investigation	28a. Date of In (Month, D	ay Year) 28b. T	ime of njury M	28c. Injury Work:	at ? es 2 □ No	28d. Describe h	ow injury occurre	d	
Division	tor the	ertification;	2 Accident 3 Suicide 6[4 Homicide	Could not be	28e. Place of I	njury - At home, fai				28f. Location (S	treet and Numbe	r or Rural	Route Number,
Ö	itel or rs afte el Dir	Cert	4 Homicide		oullaing, e	etc. (Specify)				City or Town	n, State)		
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 (Check only 2 one)	Certifying Phys Medical Examir	ician: To the bes ler: On the basis and manner s	t of my knowledge of examination and stated.	, death occurred Vor investigation	at the time n, in my opi	e, date and place inion, death occi	e, and due to the curred at the time, d	ause(s) and man ate and place, a	ner as sta nd due to	ited. the cause(s)
	To the within 2 To the complet	W	29b. Signature and title	of certifier	11		29	c. License	number	2	9d. Date signed		
•	,		100	my	Klian	ne		D00	54004		lan 1	7. 2	605
	6		30. Name and address o		mpleted cause of	out the same of th	AND THE RESERVE	нтен	may ra	WATE TO	215.2		
	Sta	te	KHANNA, SHI 31. Date filed (Month, Da	ay, Year)	e. Regis	trar's Signature	BITTUNAL	r.LGI	war, LA	VALE, MD	21502		
B	Registr	ar	JAN 2	4 2005	Cloure	1 St /6	pour						

			For State Registrar	State of M	arylan		artmer rtificat				F	eg. No.	200	15.	01580
	Physicia /Medic	al	Decedent's Name (First, Middle, La Elizabeth L. F 4a. Facility Name (If not institution, give	Kelly			4h City	Town or	Location o		2. Date of Dea Month January	Day	200 ounty of E		3. Time of Beater 0
	Examin Funeral	er	Heritage Harbour 5. Social Security Number 6.5	Health & I	Rehab	ast birthday)	If Unde	r 1 Year	Anna If Under 2	apoli 24 Hrs.	8. Date of Birtl	A	nne i	Arur	
	Director		214-40-1604 Usual Residence of Decedent 10a. State 10b. County	I	96	Yrs.	Months	Days	Hours	Min.	Jan. 2.	3, 19	08		ace (State or Foreign ny) nington, DC
	he Maryla 8a-f ehov otilied at	ector	Maryland Anne A	Arundel	100. 010	, 10w1101 LC			apoli	is		10g. Citize	an of latho		1 ☐ Yes 2 ☑ No
	th with the 23a or 2	al Dir	940 Bay Forest (Court			101. 21	p Code	21403			-	S.A		ry r
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show ship injury or other treumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Tyes 2 1 If Yes, Give Year or Dates:	?		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		I. Race - A Black, V Specify:		itc.
21215-0036	t within 72 ho liene. r than "natur the Medical	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or	5+)		dent's Usu kind of w DO NOT IOMEM	ork done d use retired	ation fu <i>ri</i> ng most)	of workin	ng		of Busin		ustry
Maryland 2	12 should be filed within 'h and Mental Hygiene. 7 is marked other than "reumatic event, the Mec	To Be C	17. Father's Name (First, Middle, Last Harry E. Long.								(First, Middle,		umame)		
Mary	d 2 sho th and h t7 is ma treuma		19a. Informant's Name/Relationship Thomas L. Kelly			1	-				Route Number				Code)
Baltimore,	permit. Pages 1 and 3 Depertment of Health Importent: If Item 27 any Injury or other tr. once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Contents)	Removal from State	, 0	lace of Dispo emetery, cre ltimor	matory or	other plac			ate /2005		ation - Cit	•	wn, State Maryland
Baltir	permit. P Depertme Importen any Injur		21. Signature of Funeral Service Lice			2	2. Name a	nd Addres	s of Facilit	y Joh	n M. Ta	aylor	Fun	era.	
	Physician /Medical Examiner	Iner	23a. Part1. Enter the Isease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	pplications that cause one for use one each a	line. Sa conseq	vence of):	ter the mo		g, such as Accd			rest,			Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of):									
.O. Box 68	death certific e attending p d for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3]Ectopic] Other (≤					23	3d. Date o Month		ry Day Year
۵.	requires that the de een signed by the a hould be detached t	by	Part II. Other significant conditions Foulue	contributing to death	but not res	ulting in the t	underlying	cause giv	en in Part I.	•	23e. Did to	_		ute to th	e cause of death? ably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed									24a. Was autop perfo 1 \(\text{Yes} \)	sy	prio dea	r to con ith?	esy findings available inpletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o				
of	ng Atei Ine	tion: To	1 ☐ Yes 2 ☐ Mo 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of In	iury	ER/Outpatie 28b. Time of Injury		28c. Injur Wor	9 NU	2	ne 5 🗍 Resid 28d. Describe I			(Specify	')
Division	et or Attending setter death. I Director: Aften d in by the fune	Certification:	3 Suicide 6 Could not determine	be 28e. Place of I	njury - At h etc. <i>(Speci</i> i		treet, facto	ory, office		2	28f. Location (S City or Tox		Number	or Rura	l Route Number,
	To the Hospitel or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fo	Medical C		Physician: To the bes iminer: On the basis and manner:	of examina		rvestigatio	on, in my o	pinion, dea		ed at the time,	date and i	olace, and	d due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				2	9c. Licens	e number	- 51		29d. Date			Day, Year)
•			30. Name and address of person who	o completed cause of	death (Iter	m 23a) (Type	, Print)	D	570	28			-5	-05)
			ADITUA CHOP 31. Date filed (Month, Day, Year)	RA, M.D.	600 strar's Sign		yeu	Ace	SK.	231	Anney	xlis	,m1	D. Z	1401
	St. Regist	ate rar	1ΔN Ω G		mai s olyni	H	de la								

Ja	mes Le	W1S		State of Ma	ryland	/ Depa	artmen	t of H			ental Hy		SOC.	~ · ·	
			1 - For Unpend Item Registrer	Z3a,Z1,Z0	a-r pe	Cei	rtificate	e of L	Death	Las			105	015	81
	Physicia	an	1. Decedent's Name (First, Middle, La.								2. Date of De Januar		2005	3. Time of 14:25	
	/Medic	al	JAMES CLARK LEWIS 4a. Facility Name (If not institution, giv.				4h City	Town or	Location of	of Death	Januar		inty of Death	14:25) M
	Examin	er	300 John Kallis L				,		svill				n Anne	a's	
	Funeral Director		212-13-2370	ex 7. Age	(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da JULY 5	th y, Year) 1972	9. Birthp Coul MA	place (State or ntry)	r Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation							I Od. Inside Cit	y Limits
	a-f sh	ctor	MD QUEEN AN	NE'S	STEV	ENSV1	LLE							1 🗌 Yes	2 X No
	or 28	Funeral Director	10e. Street and Number				10f. Zip					_	of What Cou	itry?	
	eath v	eral	319 OLD LOVE POIN	T ROAD, AP		13	216		isnanic Ori	igin? (Spe	ecify Yes or No	USA 14.1	Race - Americ	can Indian	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, them 27 Is marked other than "natural," or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			If Yes, spec		Specify:		ecify Yes or No Rican, etc.)		Black, White,	etc.	
2-0	72 hou	Completed	15. Decedent's Education (Specify only highest gra	lucation de completed)		16a. Dece	dent's Usua	al Occupa	ation during mos	it of worki	na	16b. Kind o	f Business/In	dustry	
121	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5-			kind of wor DO NOT us NICIAN)			COME	UTERS		
d 2	filed v Hygie Sther t		11 17. Father's Name (First, Middle, Last,			TECH	ILCIM	N	18. Mothe	er's Name	(First, Middle,				
ılan	2 should be f and Mental H Is marked of aumatic eve	To Be	CHARLES FLETCHER	LORD					HELE	N TE	RESA CL	ARK			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (-				I Route Numbe			Code)	
	Health Hem 27 tem 27 other tra		HELEN T. LEWIS/ 1 20a. Method of Disposition	IOTHEK	20b. Plac	e of Dispo	sition (Nan	ne of	Ī		NSVILLE Date		21666 on - City or To	own, State	
ē			1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			•	natory or o		· I	1 /06	/2005	STEVE	NSVILLI	E. MD	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fun Service Licer	isee / S	7	22	2. Name an	d Addres	s of Facilit	ty	& NEWN				- A -
ш	g ∪ E ≅ 9		23a. Part1. Enter the disease, or com	plications that called	kha-tKath		06 SH/	AMRO(CK RO	AD,	CHESTER	, MD	21619	Approximate	
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	Θ.							11631,		Interval Betw Onset and D	veen
	Physician /Medical		disease or condition resulting in death)	a. Chest In			ірттса	icea	υy ν.	LOWIT	LIIG				
	Examiner	ايا	Sequentially list conditions,	b. Frank law ex	V V - 64 / 00 - 40	esseculia.									
	nted Insit	Examiner	rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i consequer	ice oi).									
ó	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequer	nce of):									
68760,	sate be chysicia the bu	lical		. d							.				
9 X	leath certificat attending phy I for use as th	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnanc	v						23d	Date of delive	an/	
. Box	0 0 0	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at t	2 🗌 Fetal de	eath 3]Ectopic pr] Other (sp					1	Month	-	'ear
P.0	that the de led by the a detached t	Phys	9 Unknown	9∐ Unknown					:- D- 41		On Did				
ds,	es be	d by	Part II. Other significant conditions of	onthibuting to death bu	it not tazarii	ng in the ប	naeriying c	ause give	en in Pan i		1 🗆 `			ne cause of de pably 4 ⊟U	
Records,	tw requir s been s should	Completed									24a. Was		b. Were auto	psy findings a	available
l Re	The law ate has page 2	Som										rmed? 2 No	prior to co death? 1 🗖 Yes	mpletion of ca 2□ No	use of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o		_/-	COENT	
of	Phys this al dii	. To	1 Yes 2 No 27. Manner of Death	1 ∐ Inpatier	nt 2 EP	VOutpatier Bb. Time of		and the latest terminal termin	7 110		ne 5 Resid			y) SCENE	
ion	Attending in death. ector: After by the funer	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	Found, Day	Year) F		\mathbf{P}^{M}	8c. Injury Work 1 🗆 \			ubject			ridge	
Division	or Attencatter death Director: in by the	Certification:	3 X Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home . (Specify)	e, farm, str	eet, factory	, office			28f. Location (S City or Tox	vn, State)			er,
Ω	pital o		200 Costilios 1 Costifuing Ph	bay Brid	-	adan daat		-			Queen A				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 Medical Exam	ysicien: To the best o niner: On the basis of and manner sta	examination	n and/or in	vestigation,	, in my op	oinion, dea	ith occurre	ed at the time,	date and plac	manner as s ce, and due to	the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	, (200)	290		number	_			ned (Month,		
//	.)		"Hati W	Unica-t	ollo	Il.	0	0.	.C.M.	E.	J	anuary	02, 2	.005	
3	5		30 Name and address of person who	completed cause of de	ath (Item 2	3a) (Type, 111	Print) Penn	Stre	eet,	Balt:	imore,	Maryla	nd 212	:01	
174	Sta	-	31. Date filed (Month, The Year)	2005 32. Regitra											
	Registı	rar		LUUS Block	we .	K	And								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** January Donald E. Miller 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 15, 19 6. Sex **Funeral** 1**□X**M 2□ F 69 164-36-5446 1935 Director PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 2 should be tiled within 72 incurs...
i and Mental Hygiene.
7 is marked other than "natural", or Itame 23s or 28e-f show
incurrent event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 X No Director PA Franklin Greencastle 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10929 Worleytown Rd. 17225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business owner Excavating company 8 Injury or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked of any lighty or other treumatic every size. Reginald R. Miller Dora C. Mourer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce E. Miller wife 10929 Worleytown Rd., Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Jan 20 2005 Chambersburg, PA Parklawn Mem. Geradens ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility M111er-Bowersox Funeral Home 21. Signature of Funeral Service Licenses eauta M. 521 S. Washington St., Greencastle, PA 17225 Wnlu 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Massial multiorcan **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of) Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 20 No 2 🗆 No this certificate 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely tilled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 0 To the Hospitel within 24 hours a To the Funerel L 29a. Certifier f 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number HUU53418 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Hagerstown 4 31. Date filed (Month, Day, Year) State 4 Registrar

	State Registrar			rtment of I	Death	F	Reg. No.	000	U158.
husisian	1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	ith Day	Year	3. Time of Death
hysician /Medical	Helen Markey					Jaman			5:20 P.M.
Examiner	4e. Facility Name (If not institution, gi				or Location of Death		4c. County		
12.0	North Arundel				n Burnie	1		ne Ar	
neral	5. Social Security Number 6. 178–20–6534	Sex 7. Age (In y	rs. last birthday) 7 Yrs.	If Under 1 Year Months Days		8. Date of Birti (Month, Da)	Year)	9. Birthple Country	ce (State or Foreign
ctor	Usual Residence of Decedent		,			Jul. 5,	1927		PA
ral Director	10a. State 10b. County		City, Town or Loc					100	I. Inside City Limits
iot	MD Anne	Arundel		Pasade	na				1 ☐ Yes 21☑No
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country	13.
<u>a</u>	8251 Elvaton Dr.	ive		2	1122			USA	
Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of H	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Raci Blac	e - Americar	
by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑No If Yes, Give		☐Yes 2XNo			Specify	Whi	
q p	3 Widowed 4 Divorced	Year or Dates:	100 0000						
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Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle,	Maiden Sumam	e)	
To B	Joseph Sass				Hilda C	areneski	_		
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	r, City or Town,	State, Zip C	ode)
	Charles Markey/	Husband	825	1 Elvato	n Drive,	Pasadena	a, MD 2	1122	
1 1	20a. Method of Disposition		p. Place of Dispos	ition (Name of atory or other pla	(ce) Tar	Date 7	20c. Location -		
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ouce.	21. Signature of Funeral Service Lice	97) 66	22.	Name and Addre	Song D	A Sozzor	na Dark	Funo	ral Homo
a	Cotta Cil	du	49	Gov. R	Sons, P itchie Hw	y, Sever	na Park	, MD	21146
ian	23a. Pani. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final	nplications that caused the de y one cause on each line.	eath. Do not ente	r the mode of dy	ng, such as cardiac	or respiratory ari	rest,	lr.	pproximate iterval Between inset and Death
al	disease or condition resulting in death)	a. Due to lo as e cons	sequence of	at beginn	W.			-	
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by PI	Part II. Other significant conditions	contributing to death but not	resulting in the un	derlying cause giv	ven in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
ed by						1 □ Y	es 2 No	3 Probab	ly 4 □Unknown
pletec						24a. Was a	ın 24b. V	Vere autops	y findings available
Be Completed						autops	med?	leath?	letion of cause of
0	25. Was case referred to medical				26. Place of Deat			Yes 2	
ToB	examiner? 1 🗌 Yes 2 🗙 No	Hospital:	ER/Outpatient	3□ DOA Ctt		me 5 Resid		er (Specify)	
	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injui		28d. Describe h			
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Certification;	3 ☐ Suicide 6 ☐ Could not determine		t home, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Number	er or Aural A	loute Number,
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completely filled in by the fig.		and manner stated.							
	29b. Signature and title of certifier	1 0		29c. Licens	22677		9d. Date signed		-
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	20 Name and 144	Completed series of 4-14 /	tom 224\ (T 5	Perme)					
	30. Name and address of person who	completed cause of death (I	tem 23a) (Type, F	Print)	mil n	1. 21nl-	1.		

			For State	Please	State of I		d / Depa	artme		ealth and		l Hygie	ene 1	0 5	01581
			Registrar 1. Decedent's Name	a (First Middle I	a st)			illica	ie or L	Jeani	2. Date	Reg of Death	3. No! U		3. Time of Death
н	Physici	an		oseph Mc							Jai	nth	1, 20	Year 005	2:30 a M
	/Medic				ve street and number	ər)		4b. Cit	, Town, or	Location of De			4c. County		
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	Funeral		5. Social Security N		Sex 7.	Age (In yrs. la			er 1 Year	If Under 24 h	Hrs. 8 Date	of Birth			place (State or Foreign ntry)
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	or 28	lrec	10e. Street and Nu	mber				10f. Z	ip Code			100	g. Citizen of V	Vhat Cou	intry?
	th wil	alD	7090 Ma:	iden Cho	ice Lane				21	228			Ü	ISA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie markad other than "neturel", or Items 23a or 28a-1 show important: If item 27 ie markad other than "neturel", or Items 23a or 28a-1 show althy injury or other treumatic event, the Madical Examinational be patified at 1000.	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 🏿 Widowed	ied 2☐ Married	12. Was Decede Armed Force 1 XYes 2 If Yes, Give Year or Date	s? □No WWI	T	_	edent of Hi ecify Cubai 2 X No	spanic Origin? n, Mexican, Pu Specify:	? (Specify Yes uerto Rican, e	s or No-		k, White,	can Indian, , etc. White
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lar	ould be I Mental narkad c	2	Howard	McCabe						Cather	rine Wa	ard			
Maryland	and N e ma		19a. Informant's N	ame/Relationship	(Type, Print)		19b. Maili	ng Addre	ss (Street a	nd Number or	r Rural Route	Number, (City or Town,	State, Zij	o Code)
	and 2 alth a		Christo	opher Mc	Cabe/Son		2969	Hea	rthst	one Rd	., Ell:	icott	City,	MD	21042
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Ĕ	Pag ment ant: I ury o			5 Other (Spec		Bal	to. Na	at. (Cemete	ery	Tan. 5, 2005	1	Baltimo	ore,	MD
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of F	meral Service Cic	ansed DSVM	2	- i_B	Barra	nco &	s of Facility Sons itchie	P.A. S	Sever	na Par	k Fu	neral Home D 21146
	13		221. Part 1. Enter t	he disease, o con	nplications that caus y one cause on each	sed the death.	Do not en	ter the mo	ode of dying	g, such as card	diac or respira	atory arres	t,	NS OF	Approximate Interval Between
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Division of	Attending r death. sctor: Atterby the fune	ical	2 Accident 3 Suicide	6 Could not	be 290 Place of	Injury - At hor	ne farm st				28f. Loca	ation /Stre	et and Numbi	er or Run	al Route Number.
<u>></u>	after Dire	ertil	4 🗌 Homicide	determine	building,	etc. (Specify))	1001, 14010	, ooo			or Town,			
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Medical Certification:	29a. Certifier (Check only one)	1€ Certifying F 2 Medical Exc	Physician: To the beaminer: On the basis	s of examinati	vledge, deat on and/or in	h occurre	d at the tim on, in my op	e, date and plainion, death o	ace, and due occurred at the	to the cau	se(s) and ma e and place, a	nner as s and due t	stated. o the cause(s)
	To the within 2 To the complet	₩.	29b. Signature and	title of certifier				2	9c. License	number		290	I. Date signed	(Month,	Day, Year)
	- s - ō			Tana	Bond	0			n	ו רכ			11.1	- :-	
			30. Name and add	ress of person who	o completed cause	of death (item	23a) (Type	Print)	144	ンナナ			11/0) 3	
			Den een	. /	mo 7	-11 m	wido	· /	bois	0/11-	1 A.	1	Czill	0,	MD 21228
	St	ate	31. Date filed (Mor	nth, Day, Year)	32. 1 9	istrar's Signati	nte	7 0	CUICO	Lur	a, ca	100	V ///	1	~ 1000
	Regist			JAN 0 4	2005	the .	# 1	Gard							

		4	For State Registrar		State	of Ma	aryland		rtment tificate		ealth an Death	nd Me		giene Reg. No.	2005	01	585
	Physicia /Medica Examine	al er	1. Decedent's Name Anthony 4a. Facility Name (If	J. Mer	LO give street and				4b. City, To	own, or	Location of C	Ja	Date of De. Month	Day 6, 2	Year 005 ounty of Deatl		Death
	uneral rector		ilchrist i 5. Social Security Nu 155-01-68	ımber	e Center	7. Age	e (In yrs. las	st birthday) Yrs.	Tows If Under 1 Months		If Under 24 Hours		Date of Birt Month, Da	h	1timore 9. Birth New	e nplace (State cuntry) Jersey	or Foreign
Maryland	Ind at	tor	Usual Residence of 10a. State	Decedent 10b. County Howard				Town or Loc								10d. Inside Ci	ity Limits
eath with the	s 23e or 28s	Funeral Director	10e. Street and Num 848 The (10f. Zip C	97			t	Inited	n of What Co	es	
0036 nours after de	I Examiner	à	11. Marital Status 1 Never Marrie 3 Widowed	_	Armed		Ever in U.S. to 1942 1946	<u>_</u>	Vas Decede Yes, specif		spanic Origin n, Mexican, F Specify:	n? (Specify Puerto Ric	y Yes or No- an, etc.)	1	. Race - Amer Black, White pecify: Wh	e, etc.	
Maryland 21215-0036 at 2 should be filed within 72 hours aft th and Mental Hydiene.	ar then "natu	Completed	(Special Second 12		grade complet	e <i>d)</i> ge (1-4or 5		16a. Deced (Give i life. D Brok	kind of work OO NOT use	Occupa done d retired)	ition uring most of	f working			of Business/l	·	
Iryland should be file	marked oth	To Be (17. Father's Name (for Joseph Name) 19a. Informant's Name	Merlo				19b. Mailin	a Address (nciat	ta Giu	ıffre	imame) Town, State, Z	in Code)	
Baltimore, Ma	importent: if Item 27 is marked other then *natural; or Items 23e or 28e-1 show any injury or other treumatic event, the Madical Examiner must be notified at once.		Barbara A 20a. Method of Dispo 1 Burial 2 2 1 Donation	A. Carl	o/Daugh 3 □Removal fr		сеп	848 To e of Dispose of Dispose of Cre	he Olo bition (Name natory or oth mator	d St of er place Y	ation	Cour Date 8/200	t Wo	odbir 20c. Loca atons	ne, MD tion - City or 1 sville,	21797 Town, State	
Balt permit. Depart	import any inj once.		21. Signature of Fun	Collis	- toll	le	0104	41	12 01	đ Co	olumbia	a Pk.	E11	icott	s Fami City,		1043
3760, site be executed		Exa	23a. Part1. Enter the shock, or heard Immediate Cause (f disease or condition resulting in death) Sequentially list con if any, leading to immediate Enter Under Cause (Disease or in that initiated events resulting in death) Lie	ditions, nediate nigray	a	on each lin	a conseque	nce of):	A.C		AN C			rest,		Approximate Interval Beto Onset and E	ween Death
O. Box	y the attending packed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	1□Liv 4□Pr	ve birth .	of pregnanc 2 Fetal di time of dea	eath 3□	Ectopic preg Other (spec					230	d. Date of delive Month	,	⁄ear
OI 06 05 C Records, P.O	p eq	Š	Part II. Other signific	cant condition	ns contributing t	to death bu	ut not resulti	ing in the un	derlying cau	ise give	n in Part I.	_	23e. Did to	_	-	the cause of debably 4 🗆 U	
- L	ate has	e Completed	25. Was case referre	ed to medical							26. Place of	- Dooth (C		med?	24b. Were autoprior to condeath? 1 Yes	opsy findings a ompletion of ca	vailable iuse of
on of ding Phys	After this funeral di	0	examiner? 1 Yes 2 27. Manner of leath Natural Accident Suicide		28a. Da	Inpatier ate of Injur Month, Day	Year) 21	VOutpatient Bb. Time of Injury	M 280	Other	r: 4 🗆 Nursir	ng Home 28d.	5 🗌 Resid Describe h	ence 6 cow injury o			oice
Divi	To the Funeral Diractor: completely filled in by the		4 Homicide 29a. Certifier	determin	Physician: To	uilding, etc	c. (Specify)	e, farm, stre	occurred at	the time	e, date and p	place and	due to the c	n, State)	d manner as o	al Route Numb	
To the Ho within 24	To the Fu	Medical	(Check only one) 29b. Signature and to		xaminer: On th	ne basis of nanner star	tea.		29c. L	icense	number		2	29d. Date s	igned (Month,	Day, Year)	
(A) 02			30. Name and addre	ss of person w	tho completed c	- 12	eath (Item 2	3a) (Type, F	Print)	Ch	s dos	CX	Ba	Son.	MY	2,200	5
	Stat Registra	F	31. Date filed (Month	AN 1 0			r's Signatur	* A	antis					-10	,		

		1- For State of Maryland / Department Certificate	t of Health and Men e of Death	tal Hygien	4005	01586
Physicia /Medic		1. Decedent's Name (First, Middle, Last) James D. Moore		Date of Death	ay Yeer	3. Time of Death
Examin	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Fort Washington Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24 Hrs. 8, p	M.C.	c. County of Death	ace (State or Foreign
Funeral Director		243-22-1680 XXM 2□ F 89 Yrs. Months Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Days Hours Min. (Month, Day, Yea _ 0 – 2 7 – 1	5	ace (State or Foreign N.C.
the Marylan 28a-f ehow	Funeral Director	VA Norfolk 106. Street and Number 106. Zip	Code	10g. C	Citizen of What Coun	1√PYes 2 No
s 23a of	eral Di		505		SA 14. Race - America	an Indian
1215-0036 within 72 hours after death with the Maryland one. than "natural", or Itams 23s or 28s-f show in Marical Examiner must be marified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Amed Forces? 14. Was Decedent Ever in U.S. Amed Forces? 15. Was Decedent Ever in U.S. Amed Forces? 16. Yes Cive Year or Dates:	ent of Hispanic Origin? (Specify ify Cuban, Mexican, Puerto Rica)	n, etc.)	Black, White, 6	
21215-0036 ad within 72 hours afi gjene. er than "natural", or i, the Madical Exerti	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 16a. Decedent's Usua (Give kind of wor life. DO NOT us Disabl	Occupation k done during most of working e retired)		Kind of Business/Ind	ustry
Maryland 2 42 should be filed th and Mental Hygi 77 Is marked other treumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) June Moore	18. Mother's Name (Fire Pheobia	st, Middle, Maide	en Sumame)	
P. and Heal			(Street and Number or Rural Roll age Drive, O	xon Hi		20745
Pa Pantine ury		1 Structural 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Lincoln Ceme	her place)		rtsmouth	
Balt permit. Depart Import any inji			Funeral Hom		Wilson	Rd, Norfol
Physician and periodical examiner and periodical examiner while private transit	Ilcal Examiner	shock, or heart failure. List only one wuse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	ravial h	ruis	rbage	Goset and Death
Records, P.O. Box 6876 The law requires that the death certificate E tte has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pre 4 □ Pregnant at time of death 5 □ Other (spe			23d. Date of deliver Month	y Day Year
cords, P.	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
	Completed		1	24a. Was an autopsy performed?	prior to con death?	sy findings available inpletion of cause of
on of ling Phy After this funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	3c. Injury at Work? 1 Yes 2 No office 28f. L	5 ☐ Residence Describe how inj	ury occurred and Number or Rural	
Divisic To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred a 2 Medicel Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, and d in my opinion, death occurred at	due to the cause(the time, date ar	s) and manner as stand place, and due to	ited. the cause(s)
To the within To the Complex	Me	29b. Signature and title of certifier A. M. Alubhaus M. D.	00 460 46	29d. D	ate signed (Month, D	-
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amir Mirza-Alikhani, 11711 Livingst	on Road, Ft.	Washi	ngton, M	d. 20744
Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 2005 32. Registrar's Signature				

			State of Maryland / Depa	artment of Health and Martificate of Death	ental Hygi	_	01587
			Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physicia /Medic		Mary Amy Nolan		Jan	07 2005	0700 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Chesapeake Woods Center	Cambridge		Dorches	
	Funeral Director		5. Social Security Number 218-52-3544 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 3,	Year) 9. Birth Coul 1917 Mar	place (State or Foreign ntry) Yland
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
`	Maryla a-f ahor Ilied al	tor	MD Dorchester	Cambridge			1 ☐ Yes 2 XNo
)	or 28s	Jirec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
3	ath w	rai	5010 Deep Point Road	21613	" . V N .	USA 14. Race - Americ	and tadion
36 7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any figury or other traumatic avant, the Medical Eracia at Francia Control once.	by Funeral Director	1 Never Married 2 Married 1 XYes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	cry tes or No- Rican, etc.)	Black, White,	
2-0	72 hou	eted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	ng 1	6b. Kind of Business/In	ndustry
121	within ane. Ihan "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) nurse		health de	ot.
d 2	filed Hygie Dithar ant, III		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N		Pot
/lan	should ba and Mental markad o	To Be	Ralph Payne Asplen	Hazel	Collins		
Maryland 21215-0036	d 2 sho th and I 7 is ma traums			ng Address (Street and Number or Rura Box 41, Woolford		City or Town, State, Zip 1677	o Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		20a Method of Disposition 20b. Place of Disposition			20c. Location - City or To	own, State
ij	Page tment tant: I		`4 Donation 5 Other (Specify) Maryland V	eterans Cem. 1/11	The state of the s	Hurlock, M	
Ball	permit Depar Impor any in once.			2. Name and Address of Facility Th 700 Locust St., Cam		neral Home MD 21613	P.A.
	Pnysician /Medical	Z 71	23a. Part Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ter the mode of dying, such as cardiac of Hem F Philop	r respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	Examiner Asician and and te burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Due to (of as a consequence of):	Hemt Pailur Ley Disense			
.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	quiras that lhe n signed by th uld be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the u Advanced Debilitysed S	inderlying cause given in Part I.		acco use contribute to t	he cause of death?
Vital Records,	: The law requiras cate has been sign ; page 2 should be	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to co death?	opsy findings available impletion of cause of
Vit.	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien	26. Place of Death		nce 6 ⊡Other (<i>Specii</i>	6.1
of			27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at	28d. Describe ho		79)
ion	Attanding I r death. actor: After by the funer	atio	1 Xatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attane after death Diractor: in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town	reet and Number or Rura , State)	al Route Number,
_	To tha Hospital or At within 24 hours after of To tha Funaral Diract completely filled in by	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat and manner stated.	th occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s ite and place, and due t	stated. o the cause(s)
.	To the within To the comple	Me	29b. Signature and title of certifier What follows the signature and title of certifier.	29c. License number	29	Od. Date signed (Month,	Day, Year)
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Marchael J. Facilities M. J. 31. Date filed (Morth Day York) 32. Resistrar's Signature	Print) 302 Pulliws A	Husto	k md 21	643
	Sta Regist		31. Date filed (Month, Day Near) 0 2005 32. Resistrar's Signature	berte	, 0 10 1		<i></i>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of N	-	epartment d Certificate	f Health and N of Death		ene . No. 2005	01500
		41	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici Medic	-9	Hope E. Osterling				Month January	6, 2005	10:10 P M
	Examin		4a. Facility Name (If not institution, give street and number Homewood at Crumland Fa	•		m, or Location of Death erick		4c. County of Deat Frede	h
	uneral irector		5. Social Security Number 6. Sex 7 324-05-9204 1 M 2 XF	Age (In yrs. last birth 86 Y		ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth Month, Day, Y May 23,	9. Birt 1918 III	hplace (State or Foreign untry) inois
pur	2 1000		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Aaryla	short and a	ö	Maryland Frederick		rederick				1 ☐ Yes 2 → No
the A	288-	Director	10e. Street and Number	F.	10f. Zip Co	de	100	. Citizen of What Co	untry?
h with	32. or 81.be	0	7404 Willow Rd. Apt. 322		217	n 2		United S	tates
deat	ems 2	Funeral	11 Marital Status 12. Was Decede	nt Ever in U.S.		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	rican Indian,
d Z 1 Z 1 2-0000 filed within 72 hours after death with the Maryland	n result and weather typens. It is marked other than "neturel", or items 23s or 28e-1 show other traumatic event, the Medical Examinar must be notified at	by	Armed Force 1 Never Married 2 Married 1 Yes 2 3 Widowed 4 Divorced Year or Date:		1 ☐ Yes 2 📆		Though, Old.)		hite
2 ho	fical	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual O	one durina most of work	ina 16	b. Kind of Business/	Industry
ig ig	Me	mple.	Elementary/Secondary (0-12) College (1-4c	or 5+)	life. DO NOT use r	itired)		C	.
y peli	ther t		17. Father's Name (First, Middle, Last)	560	cretary	18 Mother's Name	e (First, Middle, Ma	Governmen	C .
should be f	and marked other than aumatic event, the Me	To Be	Clarence Curtis				y Smith	iden Sumame)	
	Is me		19a. Informant's Name/Relationship (Type, Print)			reet and Number or Rur.			
1 and	m 27		Mark Osterling / Son 20a. Method of Disposition			Hill Rd.,	-		
ges 1	or of		1 ☐ Burial 2 XCremation 3 ☐ Removal from Sta		Disposition (Name of crematory or other	11/0/2	2005	c. Location - City or	
it. Pe	ortent injury		. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Frede	rick Crem	atory			, Maryland
per P	Importent: If item 2 any injury or other 2000.		Yourtney Stande	7	1621 Opo	ssumtown Pi	ke, Frede		
			23a Part1. Enter the dispase, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do no	ot enter the mode of	dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	rsician		Immediate Cause (Final disease or condition resulting in death)	elron.	sules o	ander			~ 2 weeks
	ledical aminer		Due to (or	as a consequence of	f):				
t.		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of	f):				
cuted	ndransit	Examiner	Cause (Disease or injury that initiated events						
5 exe	ian ar ırial-tı	Ex	resulting in death) Last Due to (or	as a consequence of	f):				
icate be executed	physician and s the burial-transit	edical	d						
	ding p se as		IF FEMALE: 23c. If yes, outcome	ne of pregnancy				2212111	
ath	igned by the attending be detached for use a	Physician/M	in the past 12 months?	2 Fetal death	3 ☐ Ectopic pregn 5 ☐ Other (specif			23d. Date of deli Month	very Day Year
j eg	y the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown		o 🗆 Other (specia	//			
o, T	ned b	by Pl	Part II. Other significant conditions contributing to death	but not resulting in	the underlying caus	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
require	(I) 77		segue desordes				1 ☐ Yes	2 10 No 3 □ Pro	obabiy 4 🗆 Unknown
	S C1	Completed	demestre				24a. Was an autopsy		topsy findings available ompletion of cause of
T Per	or deaut. rector: After this certificate has b by the funeral director, page 2 s	Som					performed	d? death?	2□ No
cien:	ertific ector,	Be (25. Was case referred to medical examiner?				(Check only one)		
Physi	this cral dire	2		atient 2 ER/Outp				e 6 Other (Spec	ify)
ding d	After funer	tion	1 ☑Natural 5 ☐ Pending (Month, I			injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
Atten	ctor: y the	fica	3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farr				at and Number or Ru	ral Route Number,
2 5	Dire	Certification;	4 Homicide determined building,	etc. (Specify)			City or Town, S	State)	
To the Hospitel or Attending Physicien:	To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner	s of examination and	death occurred at the for investigation, in	ne time, date and place, my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the	To the	Me	29b. Signature and title of certifier) /	29c. Li	cense number	29d.	Date signed (Month	, Day, Year)
			Thus Glife	zyn.	DL	30496	1	17/20	00
(6	6		30. Name and address of person who completed cause of	f death (Item 23a) (T	Type, Print)	1251 / Fr	1 1		
			Francis E. Becker	MP strar's Signature	300 W. 9	172 SI /2	Levely 1	md UT	
	Sta Registr		31. Date filed (Month Ray Year) 2005 32. Fegi	Star's Signature	Marke				

T.O.D 10:10pm

D.O.D. 1-6-05

known to physicians as: Hope C. Osterling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LEONARD THOMAS PARKS, JR. January 6,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing & Rehabilitation Center Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9/6/1922 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days **X** 2 □ F 82 MD Director 215-12-6748 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant; if item 27 is marked other than "natural; or items 23s or 28e-1 show injury or other traumatic event. It a Medical Exactional teamwilled at 1 ☐ Yes 🏋 💢 o Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Anchor Way 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No WW If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married WWII Maryland 21215-0036 1 ☐ Yes 2 ☐ Yoo Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tavern Owner/Operator 11 Leonard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Leonard T. Parks, Sr. Lillian Ruby Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 11412 Quillin Way Berlin, MD 21811 Leonard T. Parks, III 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/10/05 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department Important: If sny injury o Cape Henlopen Crematory 4 Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ntarx Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 20 No or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 20 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nerel Director: , filled in by the f 2 Accident Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital within 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and () pleted cause of death (Item 23a) (Type, Print) C.H. 6+ odulia us 31. Date filed (Month, Day, Year)

IAN 10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2005 Glendola Pritchett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DORCHESTER HOSPITAL DORCHESTER GENERAL AMBRIDGE If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 200 F Yrs Director 220-34-9336 66 Sept.20,1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Madical Example in the harding all 1 PYes 2 No Maryland Dorchester Cambridge Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21613 721 Cornish USA Drive Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 10 Sitting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Wilbert Pritchett Marian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other training once. 721 Cornish Drive, Cambridge, Maryland 21613 <u>Shirley Jones / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 01-15-2005 Salem, Maryland 21, Signal 22. Name and Address of Facility Bennie Smith Funeral Home 524 Race Street, Cambridge, Maryland 21613 Approximate Interval Between Onset and Death ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ptice mia Physician P /Medical Due to (or as a consequence of) Examiner End Sta Renord Sequentially list conditions if any conditions immediate cause. Enter Underlying Cause (Disease or injury Examiner the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Tes 2 3 10 Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death. investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 1-10-01 47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE MD 21613 TIMANUY 300 AURORA STREET

State Registrar

31. Date filed (North Day, Year) 2005

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			= State Registrar		Ce	rtificate of	Death		eg. No. 🕻	2005	0/59	- Control
	nysicia Medic			JART	SAC			2. Date of Dea Month Jan	17,	Year 2005	3. Time of Death 8:15 A M	
E:	xamin	er	4a. Facility Name (If not institution, giv		Y 4		or Location of Death			unty of Death		
F			Potomac Valley 5. Social Security Number 6. S		rs. last birthday		kville	8. Date of Birth	IvI	ontgo		_
Dire	neral ector			700.	7] Yrs.	Months Days		8. Date of Birth (Month, Day,	1933	Ma	place (State or Foreign intry) aryland	_
Marylan	Medat	tor	MD. Hari		City, Town or L		√hite Ha	.11			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
with the	DE TO	Funeral Director	10e. Street and Number			10f. Zip Code	02767	1	_	of What Cou	-	
eath v	THE	eral	2927 Bradenba	augh Road 12. Was Decedent Ever in	niis 13	Was Decedent of I	21161	ecity Ves or No-		Race - Ameri	states	_
IIIQ Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland be lygiene.	avant, the Medical Ever-liner must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No	.952	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,		
72 hou	affeat E	Completed by	15. Decedent's E (Specify only highest gra	ducation	16a Dece	dent's Usual Occur kind of work done	pation during most of work d)	ing	16b. Kind	of Business/Ir		
2 should be filed within and Mental Hygiene.	the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	IIT e .	Weld			C	onstr	uction	
be file	avant,	Bec	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle, I	Maiden Sui	mame)		
and Ment	natic a	2	William		Sacks		Alve				Weidner	
d 2 sh th and	traum		19a. Informant's Name/Relationship (Nancy J. Sacks				and Number or Run 1baugh R				p Code) 21161	
1 and Health	othar		20a. Method of Disposition		b. Place of Dispo	osition (Name of matory or other pla				ion - City or T		_
Dallinor Demit. Pages Department of	injury or other traumatic		1		y _n Vall	ey Mem.	Gar 2	005	Timo	nium,	Maryland	1
permit. Pages Department of h	any inj		21. Signature of Euneral Syrvice Lice	isolo bland	2	2. Name and Addre	- u	rretts on Fun				
	10		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.)	ter the mode of dyin				Home	Approximate Interval Between Onset and Death	-
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obe executed estician and	ourial-trans	Il Examiner	Cause (Dissass or injury that initiated events resulting in death) Last	CDue to (or as a cons	sequence of):							-
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To the Hospital or Attanding Physician: The law requires that the death certification the flows after death. To the Fundand District After this cardinals has been signed by the attending the the standing on the fundant of the fund	should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of good Unknown	etal death 3	□Ectopic pregnanc □ Other (specify)	у		23d.	Date of deliv Month	rery Day Year	
s that t	e deta	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did tot	acco use	contribute to t	the cause of death?	_
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To the Hospital or Attanding within 24 hours after death.	in by the fi	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	18 290 Place of Injury A	At home, farm, st		Yes 2 □No	28f. Location (St. City or Town	reet and N. n. State)	umber or Run	al Route Number, .	
Hospital 24 hours a	completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifying Property (Check only one)	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the till evestigation, in my c	me, date and place, opinion, death occur	and due to the cared at the time, da	use(s) and ate and pla	d manner as s	stated. o the cause(s)	-
To the within	comple	Mec	29b. Signature and title of certifier			29c. Licens				gned (Month,		
/			1 /mend	Elw slt	MI) D3	8262		Jan	119,2	2005	
5		550	30. Name and address of person who 'Dr A Mend	completed cause of death (1tem 23a) (Type, 2 40 l	Print) Resea	vch BL	VD Su	ite	330	2005 ROCKVILLE MD 20850	_
: R	Sta egistr		31. Date filed (Month, Pay, Year) 4	32. Resistrar's Si	gnature	Smill 1					346	-

		•	1 - For State Registrar	State of Maryland /		artment rtificate			ind M		iene g. No.	200	5 0	1592
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Deat Month	Day			of Death
1	/Medic	al	Carrie Tilghr 4a. Facility Name (If not institution, give sti		1	4b. City. T	Town, or	Location o	f Death	January	1	1 2005 County of Deet		5 A M
	Examin	er	Mallard Bay Nursi				mbri					Dorche		
	Funeral Director		5. Social Security Number 213-24-0403 Usual Residence of Decedent	7. Age (In yrs. last)	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 09-24-1	Year) 914	9. Bird Co Mary	thplace (State puntry) 1and	or Foreign
	yland how		10a. State 10b. County	10c. City, To	own or Lo	ocation							10d. Inside	
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	with the a or 2	Dire	10e. Street and Number 5706 Poplar Lai			10f. Zip (662			11	0g. Citiz	en of What Co USA	ountry?	
	death	Funeral	*	2. Was Decedent Ever in U.S. Armed Forces?	13.		ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No-	1	4. Race - Ame		
21215-0036	hours after death with the Maryland tural; or flems 23a or 28a-f show at Examiner natal be invitibed at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 MNo If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:	, rueno	rican, etc./		Black, Whit Specify: B1	ack	
ה	i within 72 hours jiene. r then "neturel", ine Medicel Exe	lete	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual kind of work DO NOT use	k done d	durina most	of worki	ng	16b. Kir	nd of Business/	Industry (
717	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Scho		'each	,			Boa	rd of E	Educati	ion
	be filed ital Hygid od other	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, M	faiden .	Sumame)		
Maryland	should nd Men marke	<u>٢</u>	Martin 19a. Informant's Name/Relationship (Type	Tilghman	9h Mailir	no Address	(Street a			etta Il Route Number,	City or	Denni		
	and 2 s ealth an n 27 ls i		Edzel Turner / 1	l l		•				1 Oak,Ma	-			
Baitimore,	es 1 a of Hea of Hear fitern r othe		20a. Method of Disposition 2 ☐ Cremation 3 ☐ Re	20b. Place	of Dispo	sition (Nam matory or oti	e of					cation - City or		
Ě	t. Pages tment of rtant: If it	1	* 4 □ Donation 5 □ Other (Specify)	Chape	distribution of the second	Cemete	The second second			-2005	Eas	ston, M	ID 2160) 1
ğ	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic of once.		21. Signature Funeral Service Licenses		F	Rennie	Smi	ith Fi	iner	al Home Easton,	Mar	vland 2	1601	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. D								yland Z	Approxim Interval B	ate etween
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3	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):			T'		· loer				11.
	0.0	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ce of):	100	4.0	1000	40	26.000.0			3	11,
	ate be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
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VIta	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	a paital:			Othe	- /	of Death	(Check only one				
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DIVISION	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	reet, factory,	office			28f. Location (Str City or Town			ıral Route Nu	ımber,
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	Vithi To t	Σ	29b. Signature and title of certifier	1,0	61	alera a		number	11		d. Date	signed (Monti	h, Day, Year)	
•			30. Name and address of person who con	VITA anoth	M	D) 0	390	1 2	1	1,	2105		
			Robert M. McDon				eet	, Eas	ton,	Maryland	21	601		
÷	Sta		31. Date filed (MAR) Day, 3ea 2005	Registrar's Signature		2000								

Physician /Medical Examiner The law requires that the death certificete be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Medical Examiner must be notified at

altimore, Maryland 21215-0020

Physiclan/Medical Examiner attending physician and for use as the burial-transit ed by the a þ should be Completed peen has page 2 Be ို After this funeral Certification:

Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physician:

death.

24 hours

within To the

rector: A

filled in by

completely

Medical

resulting in death) Last

1 ☐ Yes 2 € No

26. Place of Death Check only one Other: Nursing Home 5 Residence 6 Other (Specify)

25. Was case referre examiner? 1 ☐ Yes 2 ☐ N	
27. Manner of Death	
Natural	5 Pending
2 Accident	investig
	0 - 0 - 11

Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Tyes 2 TNo

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 ☐ Suicide

4 Homicide

Cartifying Physician: To the best of my knowledge, death consmed at the time, date and place, and thus to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

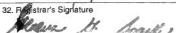
29b. Signature and title of certifier sueli

29c, License number 2859 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHAM 1 ASNEEM

State Registrar

31. Date filed (Month, Day, Year) JAN 1 0 2005



State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3, 2005 **Physician** Aldona Sorecia Smart 2:18 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 312 Oakwood Road Edgewater Anne Arundel If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 7, 1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Months Hours 1 M 2 XF 78 578-24-4242 Director Washington, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be cottilled at Edgewater Anne Arundel Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 312 Oakwood Road 21037 U.S.A. Itams 23a by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 X X ivorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is markad othar than " Elementary/Secondary (0-12) College (1-4or 5+) Catering Manager Restaurant 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aldona LaSalle Siegfried Michaelis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sorecia Donell Bladen/daughter 13210 Ovalstone Lane Bowie, Maryland 20715 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Baltimore Crematory 1/4/2005 permit. Page Department (Important: If any injury or once. Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Pervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Showas Pnysician /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician the ! IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) 4 ☐ Pregnant at time of death P.O. the detached 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records. 16 Rvs 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1□ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To the funeral 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident after death death 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 tha 20 m 23a) (Type, Print) vame and address of perston who d nodies Postury 9009 ate filed (Month, Day, Year) State JAN 0 4 Registrar

			1- State of Maryland / Depa Registrar Cen	rtment of Health and Me tificate of Death		ene 2005	01595
	- · · · ·	9	Decedent's Name (First, Middle, Last)	1	2. Date of Death		3. Time of Death
	Physici /Medic		Gene Allen Stull		Month January	Day Year 5,2005	6:22 A M
.,	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	n
3	4		Frederick Memorial Hospital	Frederick		Frederic	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. 1217-28-5940 7. The security Number 7. Security Number 8. Security Number 7. Security Number 8. Security Number 9. Se	Months Days Hours Min.	B. Date of Birth (Month, Day, Y	ear) Co.	nplace (State or Foreign untry)
			Usual Residence of Decedent		Feb. 25,	1933 Ma:	ryland
	yland		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	Mar B-f sl	ctor	Maryland Frederick Frederic	ick			1 ☑ Yes 2 ☐ No
	th th	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	ath w	rail	101 Butler Drive	21702		United Sta	ates
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avent, if a Medical Exercitive final be notified at once.	by Funerai	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	Vas Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ri ☐ Yes 2☑ No Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: W.	
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7	od wit	Son		lding Contractor		Constru	ıction
20	be filte tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma.	iden Sumame)	
<u> </u>	Meni Meni Meni Meni Meni Meni Meni Meni	L _O	Mehrl Victor Stull, Sr.	Margaret			
Maryland 21215-0036	12 sh and n Is m			g Address (Street and Number or Rural i			
e,	1 and Health em 27 ther t		Susan C. Stull, Wife 101 I			Maryland 2	
Baltimore,	ages nt of h :: If ite		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crem.	patory or other place) Janua	ry 8,		
薑	it. Printme					ederick, l	
e B	Dep Imp		162	21 Opossumtown Pike	e Frede		yland 21702
П			23a. Part1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or	respiratory arrest	•	Approximate Interval Between Onset and Death
	Physician (Medical		Immediate Cause (Final disease or condition resulting in death)	which Marie	us		20 mesente
	/Medical Examiner		Due to (or as a conseque of):	Much Mari			11 yeur
		교	Sequentially list conditions, if any, leading to immediate b. Due to (or as a coxsequence of):	Much		1	yeur
	ured I	Examiner	cause. Enter Underlying Cause (Disease or injury				
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8760,	cate be executed physician and the burial-transit	dicai	d				
9	tifical ng phy as th	0					
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	ne dea the att	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown				
Records,	sign d be		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		co use contribute to 2 □ No 3 ₽ ro	
SC	e law requ has been je 2 shoul	Completed	Chein destructes Pudvering C	recent	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
_		Com	the seteries		performed	d?/ death?	2 □ No
Vital	ysician: The l is certificate ha director, page	Be (25. Wa e referred to medical examiner?	26. Place of Death	Check onl one		
	Physic this c	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		5 Residenc	e 6 Other (Spec	ify)
Division of	Jing I	Certification:	27. Manner of Death 1 Transport	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	d. Describe how i	injury occurred	
/ISI	for Attandi after death. Diractor: A fin by the fu	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street		f. Location (Stree	at and Number or Rui	ral Route Number,
á	afor A after Dira	Serti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)	
	To the Hospitel or within 24 hours after To the Funeral Dirt completely filled in I	Medical (29a. Certifier (Check only one) 1	occurred at the time, date and place, an estigation, in my opinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	withir To th	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
1			June Elletelen MA	D30496	1	16/20	05
(30)		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) G 9+ L ST / Freder	es l. 1	2170	·/
E.	Sta Registr		31. Date filed (Month Pay, Year) 2005 32. Begistrar's Signature	sells	101/		
	98						

			1 For		aryland / Dep	artment of Health and rtificate of Death	Mental Hygie	ne
			Registrar 1. Decedent's Name (First, Middle	l ast)	<u>Ce</u>	Tillicale Of Dealif	Reg.	N2005 01596
	Physici	an	James	Earnest	Smith		Month	Day Year 3. Time of Death
	/Medic		4a. Facility Name (If not institution			4b. City, Town, or Location of Dea	Jan 15, 2	2005 9:05 pm M 4c. County of Death
	Examin	ier	11402 Kreigbau			Cumberland	- 1	
	Funeral		5. Social Security Number		ge (In yrs. last birthday)			Allegany 9. Birthplace (State or Foreign
	Director		233-68-1381 Usual Residence of Decedent	157M 20 E	63 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Ye Apr 15, 1	941 WV
	Marylan -f show fied at	tor	MD 10b. County Allec	gany	10c. City, Town or Lo	ocation Derland		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the a or 28a be noti	Direc	10e. Street and Number	m Pood NIM		10f. Zip Code	10g.	Citizen of What Country?
	s 23	era	11402 Kreigbau		Ever in II S 12	21502	S#VN-	USA
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ratment of Health and Mental Hygiene. ordant: if item 27 is marked other than "natural; or items 23a or 28a-f show rortant: if item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, ire Medical Examblar must be notified at injury or other traumatic event, ire Medical Examblar must be notified at a.g.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No 13.	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No <i>Specify:</i>	ьреспу Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	"natura	eted	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b	white b. Kind of Business/Industry
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br	e filed al Hygie other vent, II	o o	17. Father's Name (First, Middle,	Last)			me (First, Middle, Maid	
/lar	should be nd Mental marked c	ToB	Carl W. Smith)		Sue C.	(Bean) Sm	ith
Maryland	1 and 2 sho Health and em 27 ts my		19a. Informant's Name/Relationsl Sally Smith	nip (Type, Print) wife	19b. Mailii 114	ng Address <i>(Street and Number or R</i> D2 Kreigbaum Rd N	ural Route Number, Ci NW Cumber	ty or Town, State, Zip Code) land MD 21502
Baltimore,	Pages 1 a nent of Hea int: if item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation			sition (Name of matory or other place)		Location - City or Town, State
altin	permit. Page Department of Important: if any injury or once.		* 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service I			emorial Gardens ^{2. Name and Address of Facility} Scarpelli Funeral H		aVale MD
ä	Depa Impo any i		1/MA	701	W	Scarpelli Funeral F 108 Virginia Avenu		d MD 21502
	Physician /Medical Examiner		23a. Part. Er ler the disease, or shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. ME		er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
3760,	ate be executed nysician and he burial-transit	Ical Examiner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):			
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	luires than signed I	d by P	Part II. Other significant condition			nderlying cause given in Part I.		co use contribute to the cause of death?
Records,	ne law requir has been s ge 2 should	Completed by	COLON	CANCER	3		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal B	ysiclan: The is certificate hadirector, page	e Con	25. Was case referred to medical				performed 1 ☐ Yes 2	death? No 1 Yes 2 No
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	Attending Phys ir death. ector: After this by the funeral di	}	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da	ent 2 ER/Outpatier ury 28b. Time of lnjury	4 3 DOA 4 DINGSING P	lome 5 esidence 28d. Describe how in	
Division	ii or Attenc after death Director: d in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place of In	jury - At home, farm, str ic. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying 2 Medical I	g Physician: To the best examiner: On the basis of and manner st	it examination and/or in	n occurred at the time, date and place restigation, in my opinion, death occu	and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
						29c. License number	29d.	Date/signed (Month, Day, Year)
•		M	29b. Signature and title of certifier	LNALL	-1~ MD)	D34812	1	/ / -/ -
,	To the within to the comp	Me	30. Name and padress of person of			D34812	/	/18/05

	For State Registrar	State of M		artment of Health	and Mental Hygid h	ene 2005	01597
Physician	1. Decedent's Name (First, Midd		Schaefer,	TTT	2. Date of Death Month	12, 2005	3. Time of Death
/Medical Examiner	Joseph 4a. Facility Name (If not instituti Fotomac River near	-	ar)	4b. City, Town, or Location Oxon Hill	n of Death	12, 2005 4c. County of Dea Prince Geo	
Funeral Director	5. Social Security Number 265–90–8364		Age (In yrs. last birthday, 56 Yrs.		er 24 Hrs. 8. Date of Birth		thplace (State or Foreign
land ow	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or L	ocation			10d. Inside City Limits
e Mary		loun	Sterling				1 ☐ Yes 2X No
3e or 2	10e. Street and Number 41 Rutherford	Circle		10f. Zip Code 20165	109	g. Citizen of What Co USA	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural; or items 23e or 28e-f ahow any injury or other traumetic avant. The Medical Examinar must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Voc Cino	s?] No s: 1969–71	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic □ Yes 2 (No Speci	can, Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
d 2 should be filed within 72 ho In and Mental Hygiene 7 is marked other then "natur: fraumetic avent, the Medical To Be Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ont's Education est grade completed) College (1-4c	or 5+) (Give	dent's Usual Occupation be kind of work done during m DO NOT use retired) copter Pilot	ost of working	Sb. Kind of Business ergency T	Industry ransport
be filed tal Hyg d othar avant, Be C	17. Father's Name (First, Middle			18. Moi	ther's Name (First, Middle, Ma		
should nd Men marka nmeric	Joseph Fugene 19a. Informant's Name/Relation				rdie Gaul Aber or Rural Route Number, C	City or Town, State,	Zip Code)
and 2 ealth a m 27 ls har trau	Mary C. Schaef	er - Wife	41 Ru	therford Circ	cle Stelrin	ıg, VA 20	165
Pages 1 ment of H ant: If ita ury or ott	20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (natory or other place) National Cer		Arlington	
permit. Depart Import any inj	21. Signature of Funeral Servic	Man	2	2. Name and Address of Face Adams—Green		721 Elden Herndon,	
physician and the burial-transit the burial-transit the burial-transit dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Fitch Interhing Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequence of): as a consequence of):	Injuries			b
death certifi e attending d for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	ivery Day Year
	Part II. Other significant condi	ions contributing to death	n but not resulting in the u	inderlying cause given in Par	t I. 23e. Did toba 1 ☐ Yes	14	the cause of death?
The law ate has b page 2 sl					24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Suicide 6 ☐ Could	Hospital: 1 Inpa	njury 28b. Time o Injury / / / / / Injury - At home, farm, streetc. (Specify)	Other 4 1 1 1 28c. Injury at Work?	28f. Location (Stre City or Town,	injury occurred p; 4 COIII SIOM et and Number or Ri State) Perpower	It of helicipte
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physicien: To the be I Exeminer: On the basis and manner	of examination and/or in	h occurred at the time, date vestigation, in my opinion, d	and place, and due to the cau eath occurred at the time, date	M Bridge Ox	on Itill, MD
within 2 To the complet	29b. Signature and title of certif		SIGIOU.	29c. License numbe	r 29d	. Date signed (Mont	h, Day, Year)
1	+ Pameti 9	outhall, mi	7	O.C.M.E.	Jan	nuary 13,	2005
12	30. Name and address of person Pamela E. Sou	thail, MD	atravla Cionatura	111 Penn Stre	et, Baltimore	, Maryland	1 21201
State Registrar	31. Date filed (Month, Day, Yea JAN 2 4	2005 Serve	strar's Signature	de			

Amend item 24a Meritand Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year ESTER STAN LEN 0144 4M GUY ANLUARI d005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Hours Year) 15√M 2□F 92 Yrs. Director 231-18-9524 January **18.**1912 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral', or itema 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Washington MD Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 246 Marvland Avenue 21750 **USA** death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, Ite Marical Examination. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: White Completed by 3 ∑Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 6 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Stanley Hettie Eppard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Palmer Bennett/Nephew 112 Franklin Street Hancock MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 101/15/05 Harerstown, MD 21 Signature of Mineral Service Licenses 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phýsician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner V/18 the burial-transit Hospital or Attending Phyaician: The law requires that the death certificate be exec Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Pregnant at time of death 5 ☐ Other (specify) P.O. the þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 ☐ Yes 2 7 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury s after des. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide n 24 hours the Funeral Dire 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hc To the Fun completely (Check only one) To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2911 the ant 31. Date filed (MonA) 32. gistrar's Signature State 2005 Registrar

	an	1. Decedent's Name (First, Middle, La: MARCEUA	TOWIF					2. Date of Month	Da		
Aedio amin	al	4a. Facility Name (If not institution, giv			4b. City. To	own, or Lo	ocation of De	Janu		5, 200 County of D	JO
u	CI	Anne Arundel Medi	ical Center		Anr	napo.	lis			Anne	Arundel
eral		5. Social Security Number 6. S	TH OTHER	yrs. last birthday) Q2 Yrs.			f Under 24 H Hours V	in. (Month,	Day, Year)	9. 1	Birthplace (State or F Country)
ctor		128-14-5486 Usual Residence of Decedent		82 Yrs.				Nov.	24, 1	922 N	lew York
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othar traumatic		19a, Informant's Name/Relationship (Richard B. Toyle/Hii Michael B. Towle/Hii	Type, Print)	19b. Maili	ng Address (S	Street and	d Number or	Rural Route Nu	mber, City	or Town, State	e. Zip Code) 211
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any injury or other once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo cemetery, cre	matory or othe	er place)	Jan	uary 10	,		or Town, State
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any		James &	/ Passance	A B	2. Name and A arranco	o & S Rit	Sons,	P.A. Se	everna	a Park	Funeral H
e burial-transit	Ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Asbiration Due to (or as a con Due to (or as a con Due to (or as a con	sequence on.	nkinsö	N'S	disea	a se			
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			Registrar		Certifica	ate of Death		g. No.	0 01000
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	/Medic		- Michael E	=. 1aylor			1	4 05	5-4:38PM
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	er de	ŭ.	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	13. Was De	cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	specify Yes or No- into Rican, etc.)	14. Race - Am Black, Whi	
5	rs eft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes	s 2 No Specify:		Specity:	White
21215-0036	72 hours of "naturel", or	pe t	15. Decedent's E		16a. Decedent's U	leval Occupation			
က်	n 72	lete	(Specify only highest gra		(Give kind of life, DO NO	work done during most of w	orking	6b. Kind of Business	
7	the the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				Automob	
N B	be filed within 72 hours efter deeth with the Maryland Hygiene. A let Hygiene. I dether then "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	ပ္	17. Father's Name (First, Middle, Last		Manage		ame (First, Middle, M		<u>/</u>
⊆	b d la b	Be	Nelson Moore				Elizabeth		
	should nd Men marks umatic	2	19a. Informant's Name/Relationship (10h Mailine Add	ess (Street and Number or F			T- O- d-1
Ma	12 e 7			type, Print)					ZIP Code)
	f Healt item 2 other		Jean Taylor 20a. Method of Disposition	20h F	Place of Disposition (/	Point Berlin		811 Oc. Location - City or	- Town State
0	8 = 5		1 Bunal 2 Cremation 3	Removal from State	cemetery, crematory of	or other place) 1/8	/05	•	
	nit. Pag artment ortant: injury c		*4 ☐ Donetion 5 ☐ Other (Special	y) Ca		en Crematory		Frankford	
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п_	20 E 2 a		11 Jul (2)	ubale	108	William St. E	<u>Berlin, MD</u>	21811	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the deal	th. Do not enter the n	node of dying, such as cardi	ac or respiratory arre	st,	Approximate Intervat Between
3	Physician		Immediate Cause (Final disease or condition		coccil	brutere	-		Onset and Death
	/Medical		resulting in death)	Due to or as a consec		012/1/	mil		3 cays
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ĵ.	ate be executed nysician and he burial-transit	Examiner	resulting in death) Last	Due to (or as a consec	quence of);				
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	ificat g phy as th								
Rox	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of de	alivery
ň	death atte	ciai	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		(specify)		Month	Day Year
o.	the che	ysi	9 Unknown	9□ Unknown					
J	å å å	F P	Part II. Other significant conditions	contributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobe	ecco use contribute	to the cause of death?
Hecords,	uires sign	d by					1 □ Yes	s 2 €N6 3 □ P	Probably 4 Unknown
Ö	w require been si should b	Completed					24- 145	045 146	Parkara and Alberta
ě	The law cate has page 2:	m du					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
							1 ☐ Yes 2		s 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one	1	
0	this at di	2	1 ☐ Yes 2 ☐ No	1 Inpalient 2	ER/Outpatient 3		Home 5 Resider		ecity)
	ding F h. After funer	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe hov	v injury occurred	
DIVISION	Attending ir death. ector: After by the fune	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		М	1 Yes 2 No			
Ξ	of or Attend after death Director: /	Ti I	4 Homicide determined		iome, farm, street, fac	tory, office	28f. Location (Stre City or Town,	eet and Number or R State)	Rural Route Number,
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	To the Mospitel or within 24 hours after the Funerel Dir completely filled in	Med	one)	and manner stated.					
	To the To the comple	Σ	29b. Signature and little of certifier	14/1	,	29c. License number	29	d. Date signed (Mon	ith, Day, Year)
			, , ,	OK	my SICIL	44428	3	1/5/0	5
4 1			30. Name and address of person who	completed cause of death (Iter	mf 23a) (Type, Print)	1. 1.		. 0	
1	1.15		Robert	00/00	9733	Hellh-	24 PC	re B	Enle MIS
	Sta Registr		31. Date filed (Month, Day, Year)	32. egistrar's Signa	ature Local	2	(,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6:15 p^M January 4, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis Anne Arundel Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 15 M 2 F 53 212-58-7834 29, 1951 Director Maryland Sept. Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or Iteme 23a or 28a-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Arnold MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 USA 305 College Parkway filed within 72 hours after deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than " College (1-4or 5+) Elementary/Secondary (0-12) Disabled Permit. Pagas 1 and 2 should be filed w Department of Health and Mental Hygien Impurtant: if tem 27 ie marked other than any injury or other traumatic event. Its 2005. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lonzy Terry Roseanna Duff 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roseanna Terry/Mother 844 Stevenson Road Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 8, 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. CME Severna Park, MD 21146 0 23- Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm salate Cause (Final disc ase or condition resulting in death) Pnysician Necrotizen Duevalor /Medical Due to (or as a consequence of Examiner Japsus Sequentially list conditions Due to (of as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury ettending physicien and for use as the burial-transit The law requires that the death certificate be executed morric that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No been si 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 X No P 1 Tes 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Seath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the for 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier wo D0061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medica 2001 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State **JAN 0 6 2005** Registrar

Amended, 2, per 1- State Registrar 10- State Registrar 1- State Regist Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Month **Physician** 2004 January 10 16:25 Norris T. Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Chester River Hospital Kent If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 100 M 2□F Months Yrs. Director 217-14-8945 84 Mar.17 1920 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-4 show other treumatic event, It is Medical Execution retriests 1 ☐ Yes 2 X No Director Maryland Queen Annes Barclay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21607 106 Goldsboro Road USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.
Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Incinerator Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Wilson Blanche Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 ls Wilson / wife Cynthia 106 Goldsboro Road, Barclay, Maryland 21607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1 Bunal 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Daniels Cem. 101-15-2005 Barclay, Maryland 22 Name and Address of Facility
Bennie Smith Funeral Home Kur D. 426 Dover Street, Easton, Maryland 21601 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ➡Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2€ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Tes 2 No hours after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie games 00057509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Lacey, M D 516 Washington Ave., Chestertown, Maryland 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2005 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND/11 1/10/05 Reg. No. 4 Certificate of Death State Registrar AACO HEALTH DEPT. cmh 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4:00P M 2005 03Lynne Marjorie Wagner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel FutureCare Chesapeake Arnold If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 3/5XF 54 Yrs. 568 80 7474 04/03/1950 New York Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County rithan "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 938 Blue Ridge Drive death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Real Estate 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 90R9: Be Diana Hart Dodd Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 938 Blue Ridge Drive/Annapolis MD 21401 Ronald J. Wagner (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/5/05 Alexandria VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Advent Funeral & Cremation Services 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final accident days Physician disease or condition resulting in death) erebrovasc /Medical Due to (or as a consequence of) Examiner ucan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Can reast and that initiated events resulting in death) Last Due to (or as a consequence of) sician Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 mont 1 Yes 2 NO 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 2 □ No . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification; After 1 Watural 5 Pending 1 🗌 Yes 2 🗆 No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funeral C ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of or rtifier 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Hwy Millersville, MD

DHMH 17 Rev 1/2001

State Registrar

enniter 31. Date filed (Month, Day, Year) 8601

			For Stete Registrar	State of M	aryland / Depa	artment of H			iene	5 01601
	Physici		Negistrar Necedent's Name (First, Middle, La Joseph Vare					2. Date of Deat Month January	h Day Ye	3. Time of Death 3:50P M
	/Medic Examin	al -	4a. Facility Name (If not institution, given	re street and number			Location of Death		4c. County of I	
	Funeral Director		5. Social Security Number 6. S 220–16–9392		ge (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 28	Year)	Birthplace (State or Foreign Country) Maryland
	within 72 hours atter death with the Maryland ene. than "netural", or itams 23e or 28e-f ahow he Medical Examinat must be notified at		Usual Residence of Decedent 10a. State 10b. County MD Dorch 10e. Street and Number	ester	10c. City, Town or Le	Cambr.	idge	1	0g. Citizen of Wha	10d. Inside City Limits 1 ★Yes 2 □ No
	th with t	ral Dir	408 Pleasant S	t.			21613		U.S.A	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "netural", or itams 23e or 28e-f ahow any injury or other traumatic avant, the Medical Evantinat must be notified at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	ispanic Origin? (Sin, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)		American Indian, White, etc. white
Maryland 21215-0036	within 72 ho ane. than "netur na Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Busin	
land 2	ild be filed lental Hygie ked other itc avant, II	To Be Co	17. Father's Name (First, Middle, Las Elzey John Wil			occici		Johnson		plane
Mary	d 2 shouth and M		19a. Informant's Name/Relationship Thelma Willey			ng Address (Street Pleasant				_
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Baltin	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice	onsee .	2	2. Name and Addre	st St., (nomas Fur Cambridge	eral Home, MD 21	e P.A.
	Physician /Medical Examiner	J0	23a. Pard. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a	ad the death. Do not en line. 50phags a consequence of):		og, such as cardiad		9981,	Approximate Interval Between Onset and Death 2 Months
,8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
.O. Box 6	death certifi e attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of Month	f delivery Day Year
σ	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	. /	te to the cause of death? Probably 4 Unknown
I Reco	The law ate has b	Completed						24a. Was a autops perform	rio prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
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Division	a Hospital or Attanding 24 hours after death. a Funaral Diractor: After etely filled in by the fune	Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of I	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
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)	To the Hos within 24 h To the Fun completely	Me	29b. Signality and title of certifier	Smilly		29c. Licens	59887	2	9d. Date signed (/	Month Day, Year)
			30. Name and address of person who David H. Smit			o, Print) Pintail Di	c., Easto	on, MD 2	1601	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0	7 2005 ^{32. Reg}	rar's Signature	post				

-			For State Registrar		of Marylan		artment rtificate				F	Reg. No.	005	01605
	Physici /Medic	an al	Decedent's Name (First, Mid- Ruth A. Facility Name (If not institut.			ood_	4b. City, T	own. or	Location		2. Date of Dea Month Jan 16,	2005	Yeer	3. Time of Death 5:00 pm M
	Examin Funeral		Allegany Coun 5. Social Security Number	ty Nursing	Home 7. Age (In yrs.	last birthday)	Cuml	oerla			8. Date of Birt	Alleg	any	place (State or Foreign
	Director		217-10-4199 Usual Residence of Decedent 10a. State 10b. Coun	•	10c. Cit	Yrs. ty, Town or Lo	ocation				(Month, Day Oct 10,	1916	PA	10d. Inside City Limits
	th the Mary or 28a-f sho e notified)irector	10e. Street and Number	egany		Cumb	10f. Zip C	ode				10g. Citizen		1 □Xes 2 □ No intry?
9800	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show many injury or other treumatic event, the Medical Evantral must be notified at once.	Completed by Funeral Director	487 Eastern Av 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	arned 1 12. Was De Armed 1 1 Yes, 1 1 Yes, 1 Year or	ecedent Ever in U Forces? So 25 No Sive Dates:		1□ Yes 2	nt of His y Cubar No	Specify:		ecify Yes or No- Rican, etc.)	14. F E Spe	Wnit	etc.
121215-0036	filed within 72 t Hygiene. Ither then "netu		15. Deced (Specify only high Elementary/Secondary (0-12 12 17. Father's Name (First, Middle		d) (1-4or 5+)	Homer	dent's Usual kind of work DO NOT use naker	done di retired)	uring mos		- 1	16b. Kind of Own H Maiden Sum	ome	ioustry
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	s 1 and 2 si Health an Item 27 is r		William Mathe	eney s		928 Place of Disponentery, cre-	Wieres	s Av	enue		LaVal		1	MD 21502
Baltimore,	perr it. Pages Dep rtment of Imp. rtent: If i any injury or once.		1 ⚠ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	(Specify)		Mary's C	emetery		ļ		1/20/2005 me, P.A.	Cumb	erland	I MD
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Division	itel or Attures after de rel Directo	Certification;	4 ☐ Homicide dete	bu	ice of Injury - At h ilding, etc. (Speci	·ly)					City or Tou	vn, State)		ral Route Number,
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			For State		State of Ma	arylan		artment				ental Hy	giene Rog. No.	711115	\cap \Box	606
			Registrar Decedent's Name	e (First, Middle, L	ast)				· · ·	-		2. Date of De	ath		3. Time	of Death
Н	Physici		Chester	,	North	W	/ilson					Jan 17	. 200s	5 Year	2:59	9 pm ^M
	/Medic Examin				ve street and number)			4b. City,	Town, or	Location			T	County of Death		
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	28a-	rect	10e. Street and Nur	mber				10f. Zip	Code				10g. Citiz	zen of What Cou	untry?	
	3a or	Ö	13413 M	1cMullen	Highway				2	21502	2			USA		
	ms 2	ner	11. Marital Status	-	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	ent of His	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	o- 1	14. Race - Amer Black, White		
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Division	or At after d Diraci in by	Certification:	4 Homicide	determine	d 28e. Place of Inj building, et	c. (Specif	ome, farm, st y)	reet, factory	, office			City or To	wn, State))	rai moute ivui	11001,
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only		Physician: To the best aminer: On the basis o	f examina										(s)
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	10		30. Name and addi	ress of person wh	o completed cause	eath (Iten	n 23a) (Type.	Print)		1 1			/		f	
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		-	For State	State of	Maryland		artment <i>rtificate</i>			and Me		jiene	05	011	507
1. Decedent's Name (First, Middle, Last)											. Date of Dea			3. Time	of Death
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	/Medic Examin		4a. Facility Name (If not institution				4b. City, To	own, or	Location o			4c. County			
	LAdillii	G1	St. Mary's					Lec	nard	town		S	t. Ma	ary's	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	ast birthday)	If Under 1	Year	If Under		Date of Birth	1	9. Birth	place (State ntry)	or Foreign
	Director		215-32-1075	1 Ø M 2□F	72	Yrs.	Months	Days	Hours		ept.8,	1932		ary1ar	nd
	ט		Usual Residence of Decedent											404 1 1 1 1 1 1 1	Die i Lineia
	rylan how		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside (s 2 l No
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	ith th	Director	10e. Street and Number				10f. Zip 0	Code				10g. Citizen of V			
	23a	a	40549 Parsons N					206				United			
	ems err	Inel	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Ori n, Mexicar	gin? (Speci n. Puerto Ric	fy Yes or No- can, etc.)	14. Hac	e - Amen ck, White,	ican Indian, , etc.	
98	72 hours after death with the Maryland naturel', or items 23s or 28e-1 show itesi Eraminer must be notified at	Completed by Funeral	1 Never Married 2 Mari	If Yes, Give			1 ☐ Yes 2	No	Specify:			Specify	. Wh:	ite	
5-0036	urel	d b	3 Widowed 4 Divorced		es:	16a Daga	dostio Haval	Ossuna	tion			16b, Kind of Bu	usinass/lu	ndustry	
5	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other them "naturet, or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinet must be notified at ange.	lete	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use	done d	uring mos)	t of working	' I	100. Kilid of bi	72111623711	idustry	
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2		To Be Co	17. Father's Name (First, Middle,	Last)		110.	CHanre		18. Mothe	er's Name (i	First, Middle,	Maiden Suman			
au			Joseph Schi		Cr					Ele.	anor G	255			
Z			19a. Informant's Name/Relations		DI •	19b. Maili	na Address	(Street a	nd Numbe			r, City or Town,	State, Zi	p Code)	
Maryland						4054	0 Darc	ODE	M+11	Road	Leon	ardtown	MD	20650)
			Dorothy Woo	od / wire	20b. P		osition (Name			Dat		20c. Location -			
Baltimore,			1 Burial 2 Cremation		ate		matory or ou Memori		1	1_10	_2005	Leonard	town	Mars	rland
Ë			* 4 □ Donation 5 □ Other (S		Cna							Funera			
Ba			Mudde	IN ()	MOC							ardtown			
	Physician /Medical Examiner		Edward N. Brin: 23a. Part1. Enter the disease, or										, 110	Approxim	ate
			shock, or heart failure. List Immediate Cause (Final	only one cause on had	ch line.	9		-	11 .	1				Interval B Opser and	etween d Death
			disease or condition resulting in death)	a	E4900	along	170	n	W.	ر سے	(4)			Jai	ack
		Due to mr as woonsequence oi);									4,00	rell			
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ulsease or injury						this war				145		1
		Examiner													
	be executed iician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):	lial		7	De				7	1
8760,	ate be execu nysician and he burial-tra	llcal E		1	الرامعرا	Wasc	1171	2/19	M	1)2	<u>-</u> '			4/2	\triangleleft
687	certificate Iding phys			0.	-	1	1440		1				. V	7	-
×	leath certifica attending ph I for use as th	Physiclan/Med	IF FEMALE:	23c. If yes, outco					1			23d. Da	te of del	ery	
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?		th 2 Feta nt at time of d		□Ectopic pre □ Other (spe					Mo	onth	Day	Year
O.	0 0	iysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov	٧n										
۵	w requires that the tbeen signed by the should be detached	/ P	Part II. Other significant conditi	ons contributing to dea	th but not res	ulting in the	underlying ca	ause give	en in Part I	I.	23e. Did to	obacco use con	ribute to	the cause o	f death?
ds		d by							1 🗆 1	∕es 2□No	3 🗆 Pro	bably 4	Unknown		
20.	v req	Completed									24a. Was		Were au	topsy finding	s available
Re	e ta has je 2	g										rmed?	death?	ompletion of	cause of
Vital Records,	icien: Th certificate rector, pag	e Co	25. Was case referred to medica						26 Place	e of Death /	1 ☐ Yes Check only o		1 1 1 1 1 1 1 1	2 No	
		o Be	examiner?	Hasnital:	patient 2 🗆	EP/Outpatie	ent 3 🗆 DO.	Δ Othe	ac			dence 6 Oth	ner (Snec	ifv)	
of		h	27. Manner of Death			28b. Time		-		-		now injury occur		97	
Division	Attending I r death. sctor: After by the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury at Work? 1 Yes 2 No												
2	Attendideath.	fica	3 ☐ Suicide 6 ☐ Could		of Injury - At high	ome, farm, s	treet, factory	, office		28		Street and Numl	per or Ru	ral Route Nu	ımber,
Θį	of or Attences after death	erti	4 Homicide	buildin	g, etc. <i>(Specil</i>	y)					City or Tov	vn. State)			
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier 12 Certifyi	ng Physician: To the l	est of my kno	wledge, dea	th occurred a	at the tin	ne, date ar	nd place, ar	nd due to the	cause(s) and m	anner as	stated.	
	24 h 24 h 8 Fu	edical	(Check only 2 Medica one)	Examiner: On the bar and major		ition and/or i	nvestigation,	in my o	pinion, dea	ath occurred	d at the time,	date and place,	and due	to the cause	9(S)
	To the within 2 To the comple	Me	29b. Signature and title of certific	er)	1)	,	29c.	License	e number			29d. Date signe	d (Month	, Day, Year,)
	> - 0) (a)	mast b	MIN	EAL	1	D	01	5419	2	1-	20-	25	
			30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type	, Print)	*/	- 0	44					
			J. Patrick Ja	rboe, M.D.	, 2403.	5 Thre	e Not	ch R	oad,	Ho11y	wood,	Marylan	d 20	636	
	[®] St	ate	31. Date filed (Month Day Year	200E	gistrar's Signa	Aure 1	mile								
	Regist		JAN 24	2005	ه معنوا	19									

			For State Registrer	State of Maryland		artment of H		lental Hygie	2000	01608	
	o Physici	an	1. Decedent's Name (First, Middle, Last,	A	Rima	treong		2. Date of Death Month 34100000	Day Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give		12.10[4b. City, Town, or	Location of Death	JATIVERY	4c. County of Dea		
	_xaiiiii		4003 STARB			_	alltown			imore	
0	Funeral Director		5. Social Security Number 6. Sec. 1 Description 6. Sec. 1 Descript	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bin 2.7 M.15	thplace (State or Foreign ountry)	
	72 hours after death with the Maryland neturel', or teme 23a or 28e-f ehow Jisal Extributional Le multical at	ctor	10a. State 10b. County Bakli	more E	/, Town or L	ocation				10d. Inside City Limits	
	with th	Funeral Director	10e. Street and Number 4003 Starbroad	15		10f. Zip Code	0 %	10g.	Citizen of What Co. CS A		
	ne 23	eral	4003 Starbroe	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H		ecify Yes or No-	14. Race - Ame	erican Indian,	
215-0036	i within 72 hours atter death with the Marylar isine. Then "neturelt, or Iteme 23a or 28e-f ehow the Medical Extrainer to ust be neithful at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 ②No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Specify: B	e, etc. Laca	
		eted	15. Decedent's Edu (Specify only highest grad	cation (e completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ing 16i	b. Kind of Business	/Industry	
2121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	лге.		MAKER		Domes	tie	
, Maryland 2	jes 1 and 2 should be filed of Health and Mental Hyg If item 27 is marked othe or other treumetic event,	To Be C	17. Father's Name (First, Middle, Last) Willie Ploime	5				e (First, Middle, Mai	iden Sumame)		
			19a. Informant's Name/Relationship (7) Thecy13 FREWMA	rpe, Print) (Son)	19b. Mail	_	and Number or Rui	al Route Number, C Place	ity or Town, State, .	Zip Code)	
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, cre	osition (Name of matory or other place		1	c. Location - City or		
Baltimore			*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Ligens			Z. Cr) Con	The second secon	22/03/200	ansdowe	Here me	
Ba	permit. Departr Importe any Inje		> hexxyn	elle.	ħ	uller's M	e VERNAL to	u Ahrenol	D.C.	21213	
	Physician		23. art1. Enter the discrete for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory irrest, Approximate Interval Between Onset and Death Ox al death Ox al death								
ı	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	Joceth	0-30),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Examiner	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	te be executed ysician and te burial-transit	i Examiner									
687	± ≥ 5	edicai	•	d							
O. Box (at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	Ideath 3	⊒Ectopic pregnancy ⊒ Other (<i>specify</i>)		23d. Date of de Month			
ds, P.O.	uires that signed by Id be deta	by	HILDOR J. P. (A. O. C.)						obacco use contribute to the cause of death? Yes 2 No 3 Perbably 4 Unknown		
Records,	To the Hospitel or Attending Phyelcien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed	Dépression 24a					24a. Was an autopsy performer	topsy prior to completion of cause of death?		
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Dear	h (Check only one)	110		
n of		ို	1 Yes 2 No	Hospital: 1 Inpatient 2		4 Nursing H	ome 5 Presidence 6 Other (Specify) 28d. Describe how injury occurred				
		ation	1 atural 5 Pending investigation					200. Describe now again occurred			
		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specif)	ome, farm, st	reet, factory, office			Location (Street and Number or Rural Route Number, City or Town, State)		
	Hospi 24 hou Funer tely fill	Medicai		rsician: To the best of my kno iner: On the basis of examina and manner stated.							
	To the within 2 To the comple	Mec	29b. Signature and title of pertifier	berai mi)	29c. Licens	96748	Man, and	Date signed (Mont	th, Day, Year)	
•	7		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type		FALL	s Ro	BALT	0,12/2	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 5 2005	32. Registrar's Signa	ture	E .				al [col]	

		-	For State Registrar	tate of Maryland		artment of H			giene	5 01609
	Physici /Medic	an	Decedent's Name (First, Middle, Last)	Arthur Adam	S			2. Date of Dea	ath	3. Time of Death 6:26p
	Examin	er	4a. Fecility Name (If not institution, give street 11475 River Road 5. Social Security Number 6. Sex	t and number) 7. Age (In yrs. I	a et hirthday)		r Location of Death dgely If Under 24 Hrs.	8. Date of Birt	4c. County of Carol	
	Funeral Director		219-38-7214 ¹™™			Months Days	Hours Min.	DEC 28	y, Year)	Country) Florida
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
	the Mar	ector	Maryland N/A 10e. Street and Number			Baltin	more		10g. Citizen of Wha	1 X Yes 2 □ No t Country?
	th with 23a or	al Dir	3413 E. Baltimore	Street		2	1224		USA	
036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Examiner must be nutified at	by Funeral Director	Tr. Wantar Otalos	Nas Decedent Ever in U. Armed Forces? I □ Yes 2 전 No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, \	American Indian, White, etc. White
21215-0036	n 72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	ing	16b. Kind of Busin	ess/Industry
212	D 00 5	Comp	12	College (1-4or 5+)		dealer			Mail Or	der
and	e d ta b y	To Be	17. Father's Name (First, Middle, Last) Dennis Adams					e (First, Middle, et Veres	Maiden Sumame)	
Maryland	d 2 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type,				and Number or Run	al Route Numbe	er, City or Town, Sta MD 21230	
	1 and Heelt Sm 2 ther		Lawrence Arthur Adam 20a. Method of Disposition	20b. P		esition (Name of matory or other place		Date	20c. Location - Cit	
Baltimore,	00		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)		ro Cre	ematory,	Inc. $01/2$			imore, MD
Bal	permit. Pag Depertment Important: I any injury o]]	21. Signature of Tuneral Service Licensee	malel					land, Inc more, MD	
			23a. Part1. Enter the disease, or complicate shock, or heert failure. List only one complicate shock.	nata ons that caused the death ause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardiac			Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	CCNQ/ CC// Due to (or as a consequence)		cinoma	2			1 month
l.	Examiner	Ļ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ						
K	cuted od ransit	Examiner	Cause (Disease or injury that initiated events	Dae to (or as a conseq.	30,100 31).					
3760,	te be executed ysician end ne burial-transit	Ical Ex	resulting in death) Last	Due to (or as a consequence	uence of):					
99	m > 0		IF FEMALE:	If yes, outcome of pregna	incv				23d. Date o	f delivery
P.O. Box	it the death certifical by the attending phy tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	у	-	Month	Day Year
Ś	gned gned be de	by Ph	Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t		te to the cause of death?
Record	w require been si should I	eted						24a. Was	an 24b. Wei	re autopsy findings available
Re		Completed						autor perfo	ormed? dea	r to completion of cause of th? Yes 2□ No
Vital	Physician: The this certificeteral director, pag	o Be (25. Was case referred to medical examiner? 1 Yes 2 No Hos	oital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth	26. Place of Deat	th (Check only o	11	friend's
of			the same of the sa	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injui Wo	ry at rk?		how injury occurred	residence
Division	Attending in death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho			Yes 2 □ No	28f. Location (or Rural Route Number,
ā	i Si te		4 Homicide	building, etc. (Specif						
	To the Hospitel or Attence within 24 hours eiter death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1. Certifying Physici 2. Medical Examiner	an: To the best of my kno On the basis of examina and manner stated.	wiedge, deat ition and/or in	h occurred at the till vestigation, in my o	me, date and place, opinion, death occur	red at the time,	date and place, and	due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	m		29c. Licens	se number		29d. Date signed ()	Nonth, Day, Year)
	4		David Smith MI	leted cause of death (Item)29466	n 23a) (Type,	Print) Drive	-Suite :	5, Eas	ston, MI	21601
	St Regist	ate rar	31. Date filed (Month, Pay, Year)	32. Begistrar's Signa		•				
DH	MH 17 Rev 1/2		2003		33	13429				
					ORIGINA	AL				

Allen, Frances Cecelia Patrion+ Kirouan as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0 januan 8 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimure If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
 Countfy) Months Days 1 M 2 M Hours Director 217-24-454 Usual Residence of Decedent Yrs. filed withIn 72 hours after death with the Maryland 10a. State 10b. County Town or Location 10d. Inside City Limits other traumatic event, If a Medical Examinar must be notified at Director Wes 2 □ No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 # items 23a Be Completed by Funeral Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2DNo Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed withln 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sunt JOSEPIN 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 OSEPH permit. Pages 1 and Department of Healt Important: if item 2' any injury or other: <u>00059</u>. WAKE SAITO. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) RANS (EM:01 0 21. Sign (v e of uneral Service Licensee Name and Address of Facility JR ud uria BROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirately shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration pulmonitis disease or condition resulting in death) 8 howrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, artury 1 🗌 Yes 3 Probably 4 Unknown been erzuru 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 \(\sigma\) No certificate 1. Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Other: 1 🗌 Yes 2. No 1 Inpatient this 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINGLE HOSPI.

32. Registrar's Signature of

Registrar DHMH 17 Rev 1/2001

chen

5

31. Date filed (Month, Day, Year) JAN 2

Baltimore

Hospital of

Amend item#19b,20c,perFH,G839.1/25/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 JANUARY 20, **Physician** Рм **ABRAHAM** 3:32 BLUMENTHAL EVELYN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE 7 SLADE AVENUE #307 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year APR. 22, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔽 F MD 89 Yrs. 214-46-9212 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State rthen "natural", or items 23a or 28e-f show the Medical Examiner must be multiled at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 7 SLADE AVENUE #307 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No WHITE Specify: Specify. 3 X Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 3 OWN HOME HOUSEWIFE ies 1 and 2 should be filed vol Heelth and Mental Hygie of Heelth and Mental Hygie If item 27 is marked other to other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NEEDLE NEEDLE ROSE ISAAC Mailing Address / Street and Number or Rural Route Number, City or Town, State Zin Code St. Baltimore, MD 21202 SLADE AVENUE #307 - BALTIMORE, MD 21208 19a. Informant's Name/Relationship (Type, Print) MAX BLUMENTHAL / SON Pages 1 and Baltimore, 20b. Place of Disposition (Name of Reisterstown, MD 20a. Method of Disposition cemetery, crematory or other place) permit. Pages
Department of H
Important: If ite
any Injury or of 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM 01/24/2005 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the disease, or complications that caused the de unshock, or heart failure. List only one cause on each line. Immediate Cause (Final henmonia **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a) nce 17 requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. physician Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year ō 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 2 2 10 3 Probably 4 Unknown 1 Tyes Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed: 2 🗆 No 2 Z No 1 TYes certificate 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Injury Division 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident after death in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie mpleted cause of death (Item 23a) (Type, Print 30. Name and add (000 32. Redistrar's Signature State 5 Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner 7. Age (In yrs Jast pirthday) If Under 1 Y ATONGVILL TIMORE EDERIC VILLA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗹 F 216-12-7286 01,1917 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28e-f show r than "natural", or items 23a or 28e-f eho the Medical Examiner must be notified at 1 Yes 2 □ No Director ALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SA STREE Funeral 12. Was Dededent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Z No Specify. ģ BLACK 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) BEAUT INKNIWA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1208 CORNISH BENTALOU BALTO, MD 21216 ELSIE (COUSIN 51. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 31-05 4 ☐ Donation 5 ☐ Other (Specify) FOREST OWINGS MILLS, MD. 22. Name and Address of Facility BRO 21. Signature of Funeral Service Licensee TR. FUNERAL HOME chici 40 N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arfest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) ia - Severe /Medical me Examiner Due to (or as a consequence of) Examiner the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and P.O. Box 68760. Physician/Medical Due to (or as a consequence of): se esn. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? page 2 should completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: All Nursing Home 5 Residence 6 Other (Specify) 1 Yes 201No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attendl within 24 hours after death To the Funeral Director: A 6 ☐ Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste RC w 31. Date filed (Month, Day, Year) 32. Redistrår's Signature State **JAN 2 5** 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State	oi iviai yiai i		tificate of	Death	_	Reg. No. 0	15	01613
			1. Decedent's Name (First, Middle,	Last)					2. Date of De		Year	3. Time of Death
	Physicia /Medic		Suzani	ne Bac	chrach					Januar		005	4:50 AM
1	Examin		4a Facility Name (If n	ot institution, g	give street and nu	umber)			4b. City, Town, or			of Death	
1			Montgomer	y Villa	age Heal	th Care	Cente	c	Montgome			ntgom	
	Funeral		5. Social Security Nun	nber 6	. Sex 1 □ M 2 🗓 F	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days		. (Month. D	rth ay, Year)	9. Birthpla Count	ace (State or Foreign ry)
	Director	ļ	255-46-92		10 W 244 F	73_	Yrs.			AUG 29	, 1931	Geo	rgia
	pura *	ŀ	Usual Residence of D 10a. State 1	ob. County		10c. City	, Town or Lo	cation				10	d. Inside City Limits
	fanyli sho	5							57: 1	1			1 ☐ Yes 2 💹 No
	the A	6	Maryland 10e. Street and Numb	<u>Montgo</u>	mery			10f. Zip Code	omery Vil	<u>rage</u>	10g. Citizen of	What Count	ry?
	¥ è B	百			M:11 Dos	a d		2088	6			USA	
	leath	era	19301 Wa	LKIIIS	12. Was Dec	cedent Ever in U,	S. 13. \		Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N		e - America	
0	r iter	ᆵ	1 Never Married	2 Marrie	Armed F	2 🔯 No	i			no Alcan, etc.)		ck, White, e v: Whi	
21215-0020	al', o	Completed by Funeral Director	3 X Widowed 4	□ Divorced	If Yes, G Year or I	Dates:		I□Yes 2🏋 No	Specify:		Specin	. MITT	
2-0	72 ho	ted	1 (Specify	5. Decedent's	Education grade completed)	16a. Deced	lent's Usual Occu	upation e during most of wo ed)	orking	16b. Kind of B	usiness/Ind	ustry
21	thin sen	혈	Elementary/Second			(1-4or 5+)					US Pos	tal S	orvi co
21	ygien ygien er th	2	UNK.				Mail	. Handle		(Final Adiabatic			ELVICE
nd	d oth	To Be	17. Father's Name (Fi		ist)					Sandler	e, Maiden Suman	10)	
yla	Men Men marke	ဥ	Nathan Le				1 401 14 11		et and Number or F			State Zin	Codol
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Exactiner must be notified at once.		19a. Informant's Nam										
	fand Health m 27		Bryan Bis		ardian	20h P		sition (Name of natory or other pl		Date .	20c. Location		, MD 21201 vn. State
0	it of h		1 ☐ Burial 2 🕅 4 ☐ Donation 5		□Removal from	State	-						
ŧΪ	t. Pa ntmer tant: njury					Metr		natory,		1/25/05	Balti	more,	MD
Baltimore,	Depari Depari Impor eny ir		21. Signature of Fune	nd A. C	mill				ress of Facility Society				_
Ξ	002.00		Édward	A. Gre	g orchik		2	99 Frede	rick Roa	d Baltin	ore, MD	21228	
			23a. Part1. Enter the shock, or heart	disease, or called the	omplications that nly one cause on	caused the death each line.	n. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory	arrest,	1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fi	nal									
	Examiner		disease or condition resulting in death)	IIai	a		EME						
		e			,		ras a consec		💟 🕳			1	
11.	ficate be executed physician and sthe burial-transit	edicai Examiner			b		r as a consec		1415181	KHON	*	1	
-11	al-tr	Exal	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	itions, ediate		Due to (o	ras a consec	querice or).				1	
68760,	sicial b buri	cai	Cause (Disease or in that initiated events	jury	C	Due to (or	as a conseq	uence of):				+	
.89	tificating phy as the	귷	resulting in death) La	st		200 10 (0.	40 4 001100					į	
Вох	n cert	2		•	d								
	v requires that the death certificate be exect been signed by the attending physician and should be detached for use as the burial-tra	by Physician/M	Part II. Othar signific	ent condition	s contributing to	death but not resu	ulting in the u	nderlying cause g	given in Part I.	23b. Dic	I tobecco use co	ntribute to	the causa of death?
P.0	requires that the een signed by th hould be detache	h,								1[Yes 2 No	3 🗆 Prob	abiy 4 □ Unknown
	gned gned be de	by			-					-		T	
Records,	en si outd	P P								24a. Wa	s an autopsy formed?	ava	re autopsy findings ilable prior to npletion of cause
OC O	law re as be	pie										of c	leath?
æ	0 5 5	Completed								1 🗆	Yes 2 No	1 🗆	Yes 21 No
Vital	ysician: The is certificate director, pag	Be (25. Was case referre examiner?	d to medical						eath (Check only	one)		
of \	Physician: this certific ral director,	٦	1 ☐ Yes 2 ☐ N	0		•	ER/Outpatier	IL SLI DOM			idence 6 Oth)
ū	ding Pl h. After ti funera	on:	27. Manner of Death 1 Natural	5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury	W	uryat ′ork? ∐Yes 2∐No	28d. Describe	how injury occur	rea	
sio	Attending or death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	t ho	- 41-1 A11-	(28f Location	(Street and Num	her or Rura	Route Number
Division	or At after c Direct in by	Certification:	4 ☐ Homicide	determin	ed 286. Plac buil	ce of Injury - At ho ding, etc. (Specify	y)	eet, ractory, onto	8	City or To	own, State)	201 01 1 101 01	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Hospital	C	29a. Certifier 1	∕a Cortifuina	Physician: To th	ne hest of my kno	wledge deat	n occurred at the	time, date and place	e and due to the	e cause(s) and m	anner as st	ated.
	Hos 24 hc Fund etely	edicai	(Check only 2	☐ Madical E	caminar: On the	basis of examina oner stated.	tion and/or in	vestigation, in my	opinion, death occ	curred at the time	, date and place,	and due to	the cause(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	ĕ ¥	29b. Signature and ti	e of certifier	\mathcal{M}			29c. Lice	nse number		29d. Date signe	ed (Month, I	Day, Year)
	C W C C			V. .	M 1	V		He	00512	30	1-26	1-0	5
			30. Name and address	is of person w	ho completed car	use of death (Iten	1 23a) (Tvpe.						
	1		Anushirava					_	r Drive.	Ste. 20	l. Rockv	ille.	MD 20850
	Sta	te	31. Date filed (Month		32.	Pastrar's Signa	iture		,		,		
	Registr		0.,	G WAIL	2005	., 9715 Postřar's Signa	K	-			<u> </u>		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

					Certifica	ate of Death	R	eg. No.	05 01614
	Physicia		1. Decedent's Name (First, Middle, Las		108		2. Date of Dee	Day	Year 7 10 Am
	/Medic Examin		4a Fecility Name (If not institution, give	1	0-1-1	4b. City, Town, o	Tanuay r Location of Death	4c. County	
	e .		5. Social Security Number 6. So	Health & I	Kehab	EIII CO 1	S. 8. Date of Birth	Howa	
	Funeral Director			M 201 7	Yrs. Month			1930	9. Birthplace (State or Foreign Country) Mary Iand
	e Marylan 8a-f ahow Affiled at	ctor	10a. Stete 10b. County Howa	rd E	ty, Town or Location	City			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or 2	Funeral Director	3000 N. Rido	e Rd.	10f. 2	Zip Cod6 21043	1	0g. Citizen of V	Vhat Country?
5-0020			11. Marital Stetus 1. Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 DNo Specify:	Specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc.
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Us	vork done during most of w	orking	16b. Kind of Bu	usiness/Industry
2121	filed within Hygiene. ther than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Domes	use retired)		Home	
Maryland ?	nouid be filed i Mental Hygid marked other natic event, ii	To Be C	17, Father's Name (First, Middle, Last) Nathanie Fo So	n	_	18. Mother's Na	ame (First, Middle, M	· ·	ιθ)
	1 and 2 sho Haaith and i em 27 is me other traums		19a. Informant's Name/Relationship (7) Denise Wiley	niece	87/2 V	ss (Street and Nymber or F Vinands F	Rd. Kan	dallsku	n,m 21133
Baltimore,	Peges 1 ment of H ant: If iter lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation / 5 ☐ Other (Specify	Removal from State	Place of Disposition (No cometery, crematory of CR)		1-25-05C	atons	City or Town, State Ville, MD
Ball	pemit. Peg Department important: I any injury o		21. Signatury of Funeral Service Living	ie	22. Name :	and Address of F cility MARCH FILL C	370 FRENH	ILTON) PI	ASS BALTO MO
· deli			23a. Part 1 Enter the disease, or composing of heart failure. List only of	lications that caused the dear one cause on each line.	th. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	. Ische	mic (ardron	NOP	ally	Onset and Death
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	icata be executed physician and sthe buriel-trensit	Examiner	Sequentially list conditions, if env. leading to immediate	Due to (c	or as a consequence of		- 2	nua	0
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Box 68	certifi nding use ex	₹	resulting in death) Last	d	enilo	Dem	entie	L	
	e death	Physician	Part II. Other eignificant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23b. Did to	becco use cor	ntribute to the cause of deeth?
ls, P.O	as the	2					1 🗆 Ye	98 2□ No	3 □ Probably 4 □ Unknown
Records,	e law requir has bean si ge 2 should	Completed					24a. Was ar perforn	n eutopsy ned?	24b. Were autopsy findings available prior to completion of cause of death?
alF	ician: The l certificate ha				-		1 □ Ye		1 ☐ Yes 2 ☐ No
f Vital	77 10 77	0	25. Was case referred to medical examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	Other:	eath (Check only one Home 5 - Reside		er (Snecity)
n of	ding Phy. h. After thi funaral	- -	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		
Division	of a Attending I of a star deeth. Director: After din by the funa	Certification:	2 ☐ Accident investigetion 3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At h- building, etc. (Specif	ome, farm, street, factory)	1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town		er or Rural Route Number,
		edical	29a. Certifier / Certifying Phy (Check only one)	sician: To the best of my kno ner: On the besis of examine and menner stated.	wledge, death occurred tion end/or investigation	d at the time, date end plac n, in my opinion, death occ	e, end due to the ca urred at the time, da	use(s) and mar ite and place, a	nner as stated. and due to the cause(s)
	Vithin To the comp		29b. Signature and title of certifier		29	9c. License number	29	d. Date signed	(Month, Day, Year)
	A ==		\$61	me		1)3004		Janua	4 24 2004
i —	7		30. Name end address of person who co	a Men	u Ba	1 pme	May	(and)	4213
1	State	9	31. Date filed (Month, Day, Year)	32. Registrar's Signa	L' Anas	12			

DHMH 16 Rev 6/95

Carol Winn 05-0466 AKG

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		•	For State Registrar	,		tificate of i				No.2005	01615
	Dharini		1. Decedent's Name (First, Middle, Last) 1			· · · · · · · · · · · · · · · · · · ·		Date of Death	Day Year	3. Time of Death
	Physicia /Medic		CAROL JEAN	BROWN - Winn	•			,	January	20, 2005	4:48 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		f Death		4c. County of Death	
			Harbor Hospital 5. Social Security Number 6. Se	x 7. Age (In yrs. iast t	birthday)	Baltim If Under 1 Year	Ore If Under 2	24 Hrs. 8. [Date of Birth	9. Birthi	place (State or Foreign
п	Funeral Director			DM 213F 37	Yrs.	Months Days	Hours	Min.	Month, Day, Ye	ear) Cou	9101A
	, g	1	Usual Residence of Decedent	the City To					//		
	shov	'n	10a, State 10b. County	10c. City, To							0d. Inside City Limits 1 Yes 2 □ No
	the N	ect	HALY And Number	BAIT	mor	10f. Zip Code			10a.	Citizen of What Cou	ntry?
	3e or	i Di	179 W. HAMbur	a Street		212	30			USA	**
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba		in? (Specify	Yes or No-	14. Race - Americ Black, White,	
99	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ⊠No If Yes, Give		☐ Yes 2X(No	Specify:	,	, 0.0.,	Specify:	1. 1
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28a-f show the Medical Examination in indiffed at	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edit	Year or Dates:	Sa Deced	ent's Usual Occup	ation		161	o. Ki of Business/In	MERICAN dustry
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Maryland	should be nd Mental i marked o	٢	4.11/10/00	COLON		(2)		inia	LACE		0.11
Mai	C/ a = 0		19a. Informant's Name/Relationship (T	ype, Print)		Wirter	. /)	, 4	.1.	ity or Town, State, Zip	
	1 and Health tem 27 other to		VATHAME DROD 20a. Method of Disposition	20b. Place	of Dispos	sition (Name of	100	Date	200	E. MAY M.	
JOE	Pages nent of ant: If its ary or o		1 Burial 2 □ Cremation 3 □ 1 4 □ Donatjon 5 □ Other (Specify	demoval from State	tery, cren	natory or other plac	(CB)	ANUARY	29	Anskwie	Mage land
Baltimore,	permit. Pages 1 al Department of Hea Importent: If item any injury or othe once.		21. Signature of Funeral Service Licens		22	Name and Addre	ss of Facility	200 E	UNERAK	Service	2
m	8 9 E E 8		Maux m.	Cellace	34	05 W. FR	ANKL	is Stre	ex-BA	to May In	and 21227
			23a. Pet1. Enter the avease, or composite or heart a ure. List only of	lications that caused the death. Dine cause on each line.	o not ente	er the mode of dyin	ng, such as o	cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Congestive hea	art f	ailure					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):						
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0							
o,	an an		resulting in death) Last	Due to (or as a consequence	e of):						
8760,	icate be executed physician and s the burial-transit	dical	(d							
9 x	death certificate be executed e attending physician and id for use as the burial-transii	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pregnancy						23d. Date of deliv	201
Вох	atten I for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)	у			Month Month	Day Year
0		hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
o,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not resulting	g in the ur	nderlying cause giv	en in Part I.		23e. Did tobac	co use contribute to t	he cause of death?
Srd	v require been sig should b							[1 🗆 Yes	2 No 3 Prot	pably 4 Unknown
Vital Records,	e lawr has be je 2 sh	Completed							24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
E	: The cate his page	Cou							performed 1 ☐ Yes 2 💆		2 No
Vits	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	100		neck only one)	. To: (a	
of); To	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury 28b	Outpatien Time of	28c. Injur	ry at	-	Describe how	e 6 □Other (Special injury occurred	y)
ion	Attending I r death. sctor: After by the funer	atio	1 XXatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	rk/ Yes 2□N	No			
Division	l or Attendater deatl	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, str	eet, factory, office			Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	itel or irs afte ral Dir lled in										
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical		/sician: To the best of my knowled iner: On the basis of examination and manner stated.							
	To the within 2. To the complet	Med	29b. Signature and title of certifier	- 10		29c. Licens	se number		29d.	Date signed (Month,	Day, Year)
)	F S F Ö		> Zakin	Mas He		0.C.	M.E.		Ja	nuary 22,	2005
į	7		30. Name and address of person who can be seen and address of person who can be seen and address of person who can be seen as a seen and address of person who can be seen as a	completed cause of death (Item 23:			Street	t, Bal		Maryland	21201
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 5 2	32. Rigistrar's Signature		barle			, , , , ,	<u>,</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Physician 1:00 PM January 20 , 2005 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimor Hospita Gienera yland 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Days North Carolina 1 M 2 □ F Yrs Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28e-f show or other traumatic event, the Medical Examiner must be notified at 1 Ses 2 No Director Maryland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code , or Items 23s or Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) it. Pages 1 and 2 snow...
inment of Health and Mental Hygiene.
priant: If Item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be TUDIE ohnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (niece) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: I any injury o ◆ Donation 5 ☐ Other (Specify) Fores: 22. Name and Address of 21. Signal of Funeral Service Vicensee Funeral Home, le Balto, Ma. oseph North Ave 2221 Part 1. Filter the disease, or complications that caus the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (F disease or condition resulting in death) use (Final ongestive Hear Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 2□ No 1 Yes 1 Tyes 2 2 100 To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 710 5 1 Dipatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: injury Natural 5 Pending 2 No death. 1 Tyes investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar IKenna

5

31. Date filed (Mo

DHMH 17 Rev 1/2001

NWA CHUKWU, M'D

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		14	For	7.	f Marylan	d / Depa	artmen	t of H	ealth a	and Me	ental Hyg		005	01617
			State Registrer			Cei	tificate	e or L	Jeatn —		2. Date of Deat		005	3. Time of Death
т	Physicia		Decedent's Name (First, Middle,								Month	Day	Year	6 AM
	/Medic	al -	Lawrence Book 4a. Facility Name (If not institution,		mhar)		4h City	Town or	Location of	of Death	January		2005 inty of Death	1
	Examin	er	30 Maple Drive		inter)				svill				ltimor	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year			8. Date of Birth (Month, Day,		9. Birth	nplace (State or Foreign
	Director		213-05-5123	1 X M 2 ☐ F	86	Yrs.	Months	Days	Hours	WIIII.	ct.25,	1918		yland
	D >		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	shov	'n												1 ☐ Yes 2 🔯 No
	289-f	Director	Maryland Baltim 10e. Street and Number	ore		Catons	7111e 10f. Zip	Code			1	0g. Citizen	of What Co	untry?
	3e or		30 Maple Drive				212	228				USA		
	death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.			spanic Ori	igin? (Spec	cify Yes or No- lican, etc.)	14.1	Race - Amei Black, White	
ဖွ	after or Ite	Ē	1 ☐ Never Married 2 X Marri	ed 1 (2XYes	2 No	-	1 ☐ Yes :		Specify:		,			nite
8	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. Arked other than "naturel", or Items 23e or 28e-f show afte event, tra Medical Evanti ar must be notified a	d by	3 Widowed 4 Divorced	Year or D	ates: WWII	10- 5	1 1				1		of Business/l	
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12	within lene. then	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Shin	yard	wor	ker			Tron	works	3
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Jan	Ald be riked of tic ever		George Bookhulta	Z						ry We				
lar	S D E E	3	19a. Informant's Name/Relationsh				_				Route Number			
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Ore	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation		State	Place of Disponentery, crea			1 -	1/28/	0005		,	
Baltimore,	t. Pages rtment of rtent: If i njury or		 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service I 		Ne	w Cath			•					Maryland
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other <u>once</u> .	i la	Down &	Julit	_	0.0	736	Edmo	ondso	n Ave	nue; Ca	atons	al Hom ville,	e, Inc. MD 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List	anhi ana antica an	aach line							est,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	_ a W	evoilere	tic Ca	ulur	and	a	Vysca	sl			years
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):								
	1051	Į.	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consec	quence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G										
ó	te be executed ysician and e burial-transit		resulting in death) Last		(or as a consec	quence of):								
3760,		cal		d										
89 x	death certifica e attending ph id for use as th	Physiclan/Med	IF FEMALE:	230 If you or	utcome of pregn	anov					mult-	004	Data of dal	111100 = ==============================
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3	□Ectopic p		,			230	. Date of del	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		304117	_ O.1.10. (9)							
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rds	w requires that been signed to should be deta										1 □ Y	es 2□N	lo 3□Pr	obably 4 Unknown
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Ä	9 4 9	E									perfor		death? 1 🗌 Yes	2 No
Vital Records,	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					100	-	e of Death	(Check only or	ne)		
of \	S S	P	1 ☐ Yes 2 € No	Hospital: 1 =	Inpatient 2	ER/Outpatie	_		4 🗆 14		ne 5 🗷 Resid			city)
nc 0	Jing After fune	lon	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g (Mo.	nth, Day Year)	Injury	м	28c. Injur Wor 1 □	k? Yes 2.⊑		.04. 20001100 11	ow injury o		
Division	at at in	flca	3 Suicide 6 Could	not be 28e. Plac	e of Injury - At I		reet, factor	y, office		2	28f. Location (S City or Tow		lumber or Ru	ıral Route Number,
Ö	after after II Dire	Certification:	4 Homicide	build	ding, etc. (Spec	ну)					City of Yow	II, Siale)		
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the	ledical (29a. Certifier 1 【 Certifyir (Check only 2 ☐ Medical	g Physician: To th Examiner: On the	ne best of my kn basis of examin	owledge, dea	th occurred	at the tir	me, date a pinion, de	nd place, a	and due to the o	ause(s) and	d manner as	stated. to the cause(s)
	the H in 24 the F	Medi	one)	and ma	nner stated.				e number					h, Day, Year)
	To To	Σ	29b. Signature and title of certifie Charles R/N	- A 1	mo		29		478	1				2005
,	11		10	- 6	ise of death /lin	m 23a) /Tues	Print)	<i>U</i> +		/) (, ,	, 200
	6		30. Name and address of person Charles F. GRAN	m 25 11	DOI PINE	Mach	V NE	, 530	10 , BA	non	pe ino	un	5	
	St	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	N. o		-			,	,	
	Regist	rar	JAN 2 5 20	JUD Jacob	Par S.	15034								

			1- State of Maryland / Der 1-State Amend Item 7 per in G839 1-25-0	artment of Health and Mental Hy 5 Fas Prtificate of Death	giene 005 01618
	Di mini		1. Decedent's Name (First, Middle, Last)	2. Date of Do Month	Day S Year 3. Time of Death
	Physici /Medic		ERNESTINE R. BUTLER	Janu	ary 21 2005 3.30 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Ac. County of Death
			1400 N. ELLWOOD AVE. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	BALTIMORE) If Under 1 Year If Under 24 Hrs. 8. Date of Bi	nth 9. Birthplace (State or Foreign
	Funeral Director		217 26 7906 1 M 2 DF 77 78 Yrs.	Months Days Hours Min. (Month, D. JUNE 5	ay, Yeer) Country)
			Usual Residence of Decedent		
	hours after death with the Maryland turei', or items 23e or 28e-f show at Examiner mast be nutified at	2	10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits 1 X Yes 2 ☐ No
	Me M	Director	MD N/A BALTIMORE	10f. Zip Code	10g. Citizen of What Country?
	with		1400 N. ELLWOOD AVE.	21213	U.S.A.
	ns 23	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Yes or N	o- 14. Race - American Indian,
9	or iter		1 Never Married 2 Married 1 Yes 2 XNo	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
93	ours rai',	d by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:	Specify: BLACK
21215-0036	72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b, Kind of Business/Industry
12	within 72 ene. than "na	ᇤ	Elementary/Secondary (0-12) College (1-4or 5+)	KEEPER	G.B.M.C
	be filed ital Hygi id other svent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
/an	2 should be filed withlr and Mental Hygiene. Is marked other than sumatic event, tre Ma	To B	FREDERICK HANCOCK	CARRIE WATTS	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other trsumstic		1111	ling Address (Street and Number or Rural Route Numb MARLORA ROAD BALTIMORE, I	
Baltimore,	Pages 1 and 3 nent of Health int; if item 27 iry or other tra		1 St Burial 2 Ucremation 3 UHemoval from State _	ematory or other place) JANUARY 29,	2000 Scation - City or Town, State
II.				NATIONAL MEMORIAL PARK 22. Name and Address of Facility CALVIN B.	LAUREL, MARYLAND
Ba	permit. Departr Imports any inji		Demandene V. Aruga	A12 E. PRESTON STREET BA	
			23a. Part1. Enter the disease, or complications that caused the death. So not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory a	Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence of):)	
	45.00	e.	f any, leading to immediate b. Due to (or its a consequence of):	uen	
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
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8760,	ate be physici the bu	dicai	d		
9	leath certific attending pl	Med	IF FEMALE:		
Вох	attend for us	ian/	in the past 12.months?	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
o.	that the de ed by the detached	Physician/Me	1 ☐ Yes 2 D No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 5		
Q	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Records,	quires			1 🗆	Yes 2□No 3□Probably 4 thinknown
000	aw requisite should	plet		24a. Was	
R	The I	Completed		auto perfu	psychological death? 220No 1 Yes 2 10No
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of V	> 0 0	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		idence 6 Other (Specify)
n c	ing After une	ion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28d. Describe Work? M 1 ☐ Yes 2 ☐ No	how injury occurred
Division	Attending r death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		Street and Number or Rural Route Number,
Σ	in Signature	Certification:	4 Homicide determined building, etc. (Specify)	City or To	wn, State)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the nvestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier — Rugalu	29c. License number	29d. Date signed (Month, Day, Year)
)_	,	2	Sheath injures	D 30001	January 25 2005
	off		30. Name and address of flerson who complete cause of death (Item 23a) Type 560 / Loch Kall Cu Divi	D 30661 Grint) Ballinere.	(d-21239.
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 5 2005 32. Agistrar's Signature	Carle	

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crn			1- State Unpend Item		and/Dep per me	artmen rtificat	t <u>of</u> H e of L	ealth a -05 ta Death	and M as	ental Hy	/gien Reg. N	2005	01619
	Physici	an	Decedent's Name (First, Middle, Las	t)						2. Date of D Month	D	ay Year	3. Time of Death
	/Media	cal	Melvin Stewa 4a. Facility Name (If not institution, give		n, Jr.	4h Cih	Town or	Location o		Januar		0, 2005 c. County of Dea	10:05 A M
00	Examir	ıer	Harbor Hospital					imore			1	•	J/A
3	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday,	If Under	1 Year	If Under a	24 Hrs.	8. Date of B	irth	9 Bi	thplace (State or Foreign
0	Director		215-86-4335	X M 2□F	10 Yrs.	Months	Days	Hours	Min.			1964 Mar	ountry) yland
7	and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation							10d. Inside City Limits
	Mary f sho	tor	Maryland Anne Ar	undel	Brookly	n Par	k						1 ☐ Yes 2√ No
	death with the Maryland ms 23a or 28a-f show	Directo	10e. Street and Number			10f. Zip	Code				10g. C	itizen of What C	ountry?
	ath wi		304 17th Ave.				212	25			Ţ	Jnited S	tates
	er de	Funeral	11. Marital Status	12. Was Decedent Ever i	in U.S. 13.	Was Deced If Yes, spec	lent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe n, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
5-0036	72 hours after natural', or ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		1 ☐ Yes	2 √ №	Specify:				Specify: W	hite
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2	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)	O WOIKII	<i>'</i> 9			
12	Hygier ther th		12 17. Father's Name (First, Middle, Last)		Di	esel	Mech		ar's Name	(First, Middle		Automoti	ve
Maryland 2121	d be f	To Be	Melvin Steward B	ranham Cr						_	o, marce	in Sumame)	
ary	shoul nd Me marl	F	19a. Informant's Name/Relationship (7		19b. Maili	ng Address	(Street a		ror Rura		ber, City	or Town, State,	Zip Code)
	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than tther traumatic event, Ite M.		Melvin S. Branham,	Sr./Father	1065	Norm	an D	rive	Ann	apolis	, MI	21403	
altimore,	Pages 1 and of He Int; if item		20a. Method of Disposition 1 □ Burial 2 本Cremation 3 □	20 Removal from State	b. Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther place	<i>e)</i> Ј	an.	ate 25, 20	20c. I	Location - City or	Town, State
ij	permit. Pag Department Important; i any injury o		' 4 □ Donation 5 □ Other (Specify) _ 2	Metro C	to State to second contract of						Catonsv	ille, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Hyre ral Servic Licen:	See /	K	2. Name an irkle	d Addres y−Ru¢	s of Facility ddick	Fun	eral H	ome	P.A.	
			23a. Part1. Enter the disease, or comp	lications that caused the c	death. Do not en	21 Cr	ain I	Hwy .	S.E.	Glen	Burr	nie, Md	P1 9 C1 proximate
	Pnysician	9	Immediate Cause (Final	one cause on each line. Complicati									Interval Between Onset and Death
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- 8	Examiner	L	Sequentially list conditions,	b									
	ed isit	iner	cause. Enter Underlying Cause (Disease or injury	Dualto (or as a con	sequence of;:								
1	executed in and ial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):								
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68760	certificate be nding physicia use as the bu	Physician/Medical		·									
Вох	th cer tendir or use	an/N	230. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ R		∃Ectopic pr	egnancy					23d. Date of de	,
E	the at	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (sp						Month	Day Year
P.O.	law requires that the death as been signed by the atter 2 should be detached for u		Part II. Other significant conditions co	intributing to death but not	resulting in the u	nderlying c	use give	n in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
ds,	w requires been sign should be	d by		Ţ.		, ,	•			1 🗆	Yes 2	2 □ No 3 □ P	robabiy 4 🗷 Unknown
ō	law requase been	olete								24a. Was	an	24b. Were a	utopsy findings available
Be	The la	Completed								auto perfe	ormed?	death?	completion of cause of 2 □ No
/ital	iician: The lav certificate has rector, page 2	Bec	25. Was case referred to medical					26. Place	of Death	(Check only		0 1 220	20110
of V	Phyaician: rthis certificatal director,	은	1 165 2 100		2 EP/Outpatier			4 🗀 Nui				6 ☐Other (Spe	cify)
no	ding Phys h. After this funeral di	tion:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year 12-26-04	r) 28b. Time o Injury	f unk 2		at ? ∕es 2 X ⊡N		8d. Describe			المما
Division of Vital Records,	Attandil death. ctor: A	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, str			unk	-			s Assau.	ural Route Numberank
Ö	al or /	Serti	4 Homicide	building, etc. (Sp	ecify)	,		unc		City or To	wn, Stat	te)	dik
	To the Hospital or Attanding Phyaician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Phy (Check only one)	raician: To the best of my	knowledge, deat nination and/or in	h occurred a	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the	cause(s	s) and manner as	s stated. to the cause(s)
	o the ithin 2 o the omplei	Med	29b. Signature and title of certifier	and manner stated.				number				ate signed (Moni	
	F 3 F 8	0) Que I)	·				C.M.E	E.			uary 21,	
1	H del	1	30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	Print)					A.T.		
Λ. =	- Dela		ANA RU	B10, H0			n St	reet,	, Bal	timore	, M	aryland	21201
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 2	32. Registrar's Si	ignature	mark	,						

			For State Registrar	State of	Maryland /	-	artment rtificate			and M		iene	005	0	620
	Physicia /Medic	an	1. Decedent's Name (First, Middle	Blade	5						2. Date of Deat Month	Day	Year 3,00 ≤		of Death
	Examin		4a. Facility Name (If not institution Chester River	11 111	ber) Center		o i	1	Location o		м		cunty of Deat Cent	h	
	Funeral Director		5. Social Security Number 215 26- 7270	6. Sex 7	. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,		Co	hplace (State untry) Cyland	or Foreign
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County MD Ken	t	10c. City, To		cation 11 Pos	nd						10d. Inside	City Limits
	with the 3a or 28a-	I Direct	10e. Street and Number 12693 Main Str	reet			10f. Zip	Code	2166	7	1	Og. Citize	n of What Co	untry?	
36	ns after death II', or Itams 2 xaminar mur	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	12. Was Deced	2 X No		Was Deced f Yes, spec				cify Yes or No- Rican, etc.)		Race - Ame Black, White		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. othar than "natural", or Itams 23a or 28a-f show ant, the Medical Examinar must be notified at	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 1.2	t's Education st grade completed) College (1-		6a. Deced (Give life.	dent's Usua kind of wor DO NOT us artis	k done di e retired)	tion uring most	of workin)g	16b. Kind	of Business/	Industry	unk
Maryland 2	2 should be filed within and Mental Hygiene. Is markad othar than * aumatic evant, the Mee	To Be Co	17. Father's Name (First, Middle, Leo Otto S	Last) Schultz					1	larga	(First, Middle, M	1aha	n		
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-1 show any figury or othar traumatic event, the Medical Examinational Legical and once.		19a. Informant's Name/Relations Perry Blades/s 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation '4 ☒ Donation 5 ☐ Other (S	spouse 3 □Removal from S	20b. Place	L2693	•	Str	eet S	Still	Pond,	MD	Fown, State, 2 21667		
Baltii	permit. F Departme Importar any injure once.		21. Signature of Funeral Service	Licensee	*	22 S B	. Name and	Anat	s of Facility	, 3 <mark>2120</mark>	1 ^{655 W.}	Bal	timore	Stree	t
8760,	death certificate be executed Examiner e attending physician and dror use as the buriat-transit	Ical Examiner	23a. Pant1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (c	r as a consequent	Thorace of):		10			neury			Approxim Interval B Onset and	etween d Death
Box 6	death certific e attending p id for use as	Physician/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2 Fetal dea nt at time of death	ath 3□]Ectopic pre] Other (spe					230	d. Date of deli Month	very Day	Year
rds, P.O.	es gu	by	Part II. Other significant condition		ath but not resultin	g in the u	nderlying ca	ause give	n in Part I.		23e. Did tob		contribute to	the cause of	
Vital Records,	The law requir ate has been sl page 2 should	Completed									24a. Was as autops perform 1 🗆 Yes 2	/	death?	topsy finding completion of	s available cause of
of	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: Atter this certificate h. completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Xatural 5 Pendir 2 Accident investic	Hospital: 1 □ In 28a. Date or (Month) gation	- 1	Outpatier b. Time of Injury		Bc. Injury Work	r: 4 □ Nu at	rsing Hom 2	(Check only only only only only only only only	nce 6[aify)	75.
Division	ital or Attenors efter deathral Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 289. Place	of Injury - At home g, etc. <i>(Specify)</i>	, farm, str	eet, factory	, office		2	8f. Location (St. City or Town		Number or Ru	rai Route Nu	m <i>b</i> er,
	To the Hospital within 24 hours e To the Funeral Completely filled	Medical	(Check only 2 Medical one)	ng Physicien: To the l Exeminer: On the ba and mann	sis of examination		vestigation,	in my op	inion, deat		d at the time, da	ite and pl	ace, and due	to the cause	(s)
)	To To		29b. Signature and title of certifie	Poss M	D		7	D/na	036		i	119/	signed (Month	, Jay, redi)	
			30. Name and address of person Susan K. Ross m	wno completed cause $5/6/6$	of death (Item 23 Oashing to gistrar's Signature	a) (Type,	e. C	hes	fato	era 1	Md. a	162	20		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5	2005	gistrar's Signature	4	poste								

		•	State of Maryland / Depa	rtment of Health and M tificate of Death	ental Hygiei Reg.	211115	01621								
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death								
	Physicia /Medic		James Oliver Bloom		January	20 2005	18:59 M								
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death									
			Washington County Hospital		rstown		hington								
	Funeral		5. Social Security Number 6. Sex 7. Áge (In yrs. last birthday) 1 M 2 F Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreign intry)								
	Director	. }	217 12 3140 X 81		January 28.	1923	Maryland								
	land ow	Ì	10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits								
	Mary fish	ţō	Mandand	Danahan			1 ☐ Yes 2 ☐ No								
	the	Director	Maryland Washington 10e. Street and Number	Boonsboro 10f. Zip Code	10g.	Citizen of What Cou	intry?								
	3a o		308 Lanafield Circle	21713		U.S	S.A.								
	hours after death with the Maryland tural', or Itams 23e or 28e-1 show al Examinar must be modified at	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13, W	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Amer Black, White	ican Indian,								
စ္	or Ita	Fu.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	☐ Yes 2☐ No Specify:	nouv, otor,	Specify:	, 616.								
8	ural',	d by	X Year or Dates: 1946	^	1		White								
<u>5</u>	22	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of workii BO NOT use retired)	ng 16b	. Kind of Business/li	ndustry								
121	d within Jiene.	шb	Elementary/Secondary (0-12) College (1-4or 5+)			Telephone	e Company								
22	77 00		unknown 17. Father's Name (First, Middle, Last)	Lineman/Installer 18. Mother's Name	(First, Middle, Maid	den Sumame)									
auc	ould be f Mental I wrked of	o Be													
Maryland 21215-0036	s 1 and 2 should be filled f Health and Mental Hyg Itam 27 Is marked otha other traumatic evant,	ĭ	John Bloom 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address (Street and Number or Rura		Harding ty or Town, State, Zi	p Code)								
Ma	and 2 sealth ar n 27 is		123	SEAR CONTRACTOR SAN W											
ē,	s 1 and 2 Health Itam 27 I		20a Method of Disposition 20b. Place of Dispos	28 Lagafield Circle Boodsb sition (Name of atory or other place)		Location - City or T	own, Slate								
30	00		1 Burial 2 Cremation 3 Removal from State	04/5	24/2005	Deltima	es 140								
altimore,	그 된 원 글 .		21. Signature of Funeral Service Licensee	ew Cromator ame an area of Facility	24/2005	Baltimo	ie, with								
ä	Depar Impor any ir		Millorent to ke at Such 1-	Slack Funeral Home,	P.A.										
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	or the mode of dying, such as called	rike Ellicott Ci	ty, MD 21043	Approximate Interval Between								
. 5	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. A cute renal failure Due to (or as a consequence of):												
	/Medical														
	Examiner		Sequentially list conditions b. Severe met	abolic Acid	dos is		Unknown								
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
>	ecute and trans	Examine	Cause (Disease or injury that initiated events c												
60,	cate be executed oblysician and the burial-transit		Due to (or as a consequence or).												
8760,	cate ohy: the	dical	d												
9 X	The law requires that the death certific thas been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	/erv								
Вох	atten for u	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year								
P.O.	that the de led by the a detached i	ıysi	1 ☐ Yes 2 ♠No 9 ☐ Unknown												
	s that ned b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?								
rds	quires n sign	d b	LIVER CHEROSIS		1 🗆 Yes	2 No 3 Pro	bably 4 Unknown								
Records,	s been signature	ompieted	LIVER CHRROSIS ESOPHAGEAL VARICE.	2	24a. Was an	24b. Were aut	opsy findings available								
Re	The law	E			autopsy performed	2 death?	ompletion of cause of 2 X No								
Vital		O	25. Was case referred to medical	26. Place of Death											
<u>></u>	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence	e 6 □Other (Spec	ify)								
n of	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred									
Sio	tendia Jeath. tor: A the fu	catle	2 Accident investigation	M 1 Yes 2 No											
Division	for Attence efter death Diractor: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury · At home, farm, stree building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,								
	urs ef					()	-4-4-4								
	To the Hospital or Attending within 24 hours effer death. To tha Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)								
	ro the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)								
			Nemah MD	00058181		01/21/2	2005								
	h		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)		1000000	Secure and the second								
السو	9		KODUAH PEPRAH 3825.	CLEVELAND A	IE. HA	GERSTOW	21740								
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 5 2005 32. Refistrar's Signature	29c. License number D0058181 Print) CLEVELAND AN		- 77	∵								

Willie D. Covington Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-0486 State of Maryland / Department of Health and Mental Hygiene AKG For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Month Day **Physician** 20, 2005 11:30 A Januarv /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore

House I If Under 24 Hrs. Aiken Street 7. Agar(In yrs. last birthday) 1 Year Days If Under Months Social Security Number **Funeral** 12M 20 F Hours Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. Cour 28a-f show Examiner must be notified at 1 Yes 2 No Director What Country? 10f. Zip Code 10g. Citizen ō items 23e death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other theory or other treum... 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black. 1 Never Married 2 Married ☐Yes 2 Yes, Give 2 No 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
file 100 NRT use refired 15. Decedent's Education (Specify only highest grade completed) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. 184 28b. Place of Disposition (Name of) City or Town State 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Lic Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dving. Immediate Cause (Final multiple wounds Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

11 Yes 2 □ No 24a. Was an autopsy performed? 2□ No 25. Was case referred to medical examiner?
12€Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 6 wother (Specify) at scene Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation est shot after death. Found 1/20/05 2 Accident Found 11:30 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide At home Aiker street, Baltimore (140) 2132 within 24 hours a To tha Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 21, 2005

27 State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland

Registrar

death (Item 23a) (Type, Print)

				For State Registrar	State o	f Marylar		artment of hittificate of	Health and N Death		jiene 0 ()5	01623
				Decedent's Name (First, Middle, La	st)					2. Date of Deat	th	Vaar	3. Time of Death
_		Physicia		Marvi	n Cornb	lath				JAN 2	O, 200	Year)5	2:25p ^M
		/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o	or Location of Death	1	4c. County	of Death	
				Gilchrist Cente	r			Tow			Ba	altin	
		Funeral		Social Security Number 6. S	ex X⊡M 2□F	7. Age (In yrs.	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		place (State or Foreign intry)
		Director		216-34-8828 Usual Residence of Decedent	25	79	TIS.			JUN 18,	1925	Mis	ssouri
		land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
La Pu		Mary -1 sh	to	Maryland N/A			B	altimore					1 XYes 2 ☐ No
32		filed within 72 hours after death with the Maryland Hygiene. ther than Insturel', or Items 23a or 28a-f show ant, the Meulical Exam is a must be notified a	Director	10e. Street and Number 3801 Canterbury	Road A	pt. 802		10f. Zip Code	21218	1	Og. Citizen of USA	What Cou	intry?
1.		death ms 2;	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. , 13. \	Vas Decedent of I	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-			ican Indian,
Solos	5-0036	urs after	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes If Yes, Gir Year or D	2 No 194 ve 1951- ates:	-53	r ves, specify Cub 1 □ Yes 2 No		o Alcan, elc.,	Specif	ck, White	White
7	0-10	J within 72 hours jiane. r than "neturel", ins Medical Era	Completed	15. Decedent's E (Specify only highest gr.	ducation		16a. Deced	tent's Usual Occu	pation during most of wor	kina	16b. Kind of B	usiness/lr	ndustry
	2121	thin 7 e. an "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retire	ed)		7.0	-	1
2.		ed with ygiene. ser thar	Con			+	Phy	<u>sician/P</u>	ediatrici	.an ne (First, Middle, i	self o		oyed
>	Maryland	av av	Be	17. Father's Name (First, Middle, Last						a Kornbl		110)	
2	3	d 2 should th and Mer 7 Is marke traumatic	۴	David Cornblath 19a. Informant's Name/Relationship			19h Mailir	on Address (Street	t and Number or Ru			State 7i	in Code)
2	Z S			Joan S. Cornblat					ry Rd Apt				D 21218
Z		s 1 and 2 if Health item 27 l		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of natory or other pla	2001	Date	20c. Location	City or T	own, State
ay	ē	ages ent of it: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State		matory,		21/05	Baltim	ore,	MD
omblath, Marvin	Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lice		nall	č	name and Addr remation	ssociety rick Road				228
3				Dawn F. McI 23a. Part1. Enter the disease, or con	onald oplications that	aused the dea						<i>D</i> 412	Approximate Interval Between
			2 17	shock, or heart failure. List only Immediate Cause (Final	one cause on e	each line.	ctat	-	NCER				Onset and Death
		Pnysician /Medical		disease or condition resulting in death)	a Due tu	or as a consec	quence of):	e Chi	IL EIC				Jan 1
		Examiner		Conventially liet conditions	h:=							. 3	
		D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undervin Cause (Disease or injury	Due to	(or as a conse	quence of):						
- 1	11	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	guanca of):						
	60,	ata be ex ohysician the burial		,	Duc to	(01 43 4 001133	qu on o o or).						
	38760	ate ohys the	dicai		_ d		· · ·						
	P.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	tcome of pregn birth 2 Fet nant at time of lown	aldeath 3	Ectopic pregnand Other (specify)	cy			ite of deliventh	very Day Year
		that the		Part II. Other significant conditions	contributing to c	leath but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did to	bacco use con	tribute to	the cause of death?
	Sp.	uires 1 sign 11d be	d by	congestin	re he	MI	FAIL	Ne		1 □ Y	es 2000	3 🗆 Pro	obably 4 Unknown
	Division of Vital Records,	he law requir e has been si tge 2 should I	Completed							24a. Was a autop: perfor	an 24b. sy med? 2VZ No	Were aut prior to c death? 1 \(\sum \text{Yes}	copsy findings available ompletion of cause of
	ta	en: T tifficat tor, pa	O	25. Was case referred to medical					26. Place of Dea	ath (Check only or		12,100	
	2	Physiclen: this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital: 1 🗆	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	ther: 4 Nursing H	łome 5 ☐ Resid	ence 6 Ott	ner (Spec	with ospice
	0 0	ng Ph ter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	We		28d. Describe h	ow injury occur	rred	/
	Siol	eath. or: A	catio	2 Accident investigate 3 Suicide 6 Could not]Yes 2□No	000 1 11 11 10			
	Ξ	or Att fter d Sirect in by	Certification:	4 Homicide determine	200. Flac	e of Injury - At I ling, etc. <i>(Spec</i>	home, farm, st cify)	reet, factory, office	•	City or Tow	rn, State)	oer or Hu	ral Route Number,
		To the Hospitel or Attending Physiclen: The law within 24 hours after death. To the Funerel Director: After this certificate has I completely filled in by the funeral director, page 2	edical Ce		miner: On the b	pasis of examin			time, date and place opinion, death occi				
		thin 2 the or the	Med	29b. Signature and title of certifier	and mai	ner stated.	/2	29c. Licer	nse number	2	29d. Date signe	ed (Month	, Day, Year)
4		Z × Z 8		M. An-	Then	y ku	ly , w	0 Da	5205	Ú	Tonum	~ ~	20 200-
		-		30. Name and address of person who	complete	se of death (Ite	m 23a) (Type.	Print)			TOTAL		20,2005
		15		W. A. R. Le	7 6	BME	670	Al. Ch	ionly Si	4 Bali	to md	21	206
			ate	31. Date filed (Month, Day, Year)	32.1	Registrar's Sign							,
		Regist	rar	14M 9 5	วกกห	1	L	1.0.					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death - Month Physician January 2005 5:30 PM 21 H. Raymond Cluster /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Roland Park Place Baltimore N/A 6. Sex 1 M 2 □ F If Under 24 Hrs. Date of Birth (Month, Day, Year)
AUG 18, 1920

AUG 18, 1920

Birthplace (State or Foreign Mary Land 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year **Funeral** Days Months Hours 84 Yrs. 213-14-2677 Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filled within 72 hours efter death with the Meryland Department of Heelth and Mantel Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinar must be notified at abide. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 830 W. 40th Street Apt. 861 21211 IISA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Labor Law 5+ Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Cluster Rose Greenberg 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy F. Cluster/wife 830 W. 40th Street Apt. 861 Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/22/05 | Baltimore, MD 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signature of Funeral Service License Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical rears Examiner Nephrosclerosis Examiner attending physicien end for use es the buriel-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown withry disease been signed be should be dete þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed gorque heart failure 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hoepital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier gregor oro In Isabelle Tac January 21,2005 D13657 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)
17- BIMBELLE TREGRESOR, 830 W 40 4h STREET, BALTIVORE, FD, 21211 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Show It Special IAN 2 5 2005 Registrar

DHMH 16 Rev 6/95

		•	For State Registrar	State of M	aryland .	-	artment of H		and Mental H	ygiene 0 0	5 01	625	
	Physici /Medic		Decedent's Name (First, Middle, I Jimmy Var						2. Date of D Janual			ne of Death	
	Examin		4a. Facility Name (If not institution, g Caton Manor Ge	nesis Elder	Care		4b. City, Town, or Balti	more			/A		
	Funeral Director	1	5. Social Security Number 238-60-1069 Usual Residence of Decedent	. Sex 7. Ag	je (In yrs. last		If Under 1 Year Months Days	Hours	Min. 8. Date of B (Month, 1) June 6	lav Vear)	9. Birthplace (Si Country) North C	tate or Foreign Carolina	
	Maryland -I show	tor	10a. State 10b. County Maryland N/A		10c. City, T	own or Lo						de City Limits [Yes 2 □ No	
	3a or 28a	Direc	10e. Street and Number 3330 Wilkens Av	renue			10f. Zip Code	1229		10g. Citizen of Wh	nat Country?		
36	d within 72 hours after deeth with the Maryland plene. I than "natural", or ttems 23a or 28a-f show the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🙀 No	ispanic Ori in, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)		American India White, etc. White	an,	
21215-0036	within 72 hou ine. ihan "natura ia Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mosi	t of working	16b. Kind of Bus	·		
Maryland 2	be filed ntal Hygi ed other event.	To Be Co	17. Father's Name (First, Middle, La Burris Van Cli	•		L	itmer		or's Name <i>(First, Midde</i> Shelia Cart	e, Maiden Sumame			
	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship Jacob Hixson, St			26217	Jones W	harf	er or Rural Route Num Road Holly				
Baltimore,	permit. Pages 1 and Department of Heelt Important: If Itam 2 any injury or other once.	- Complete State S	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 14 ☐ Donation 5 ☐ Other (Spe			o Cre	esition (Name of matory or other place) ematory I	nc.	1/21/05	/05 Baltimore Maryland			
Balt	permit. Departi Importi any in]		21. Signature of Funeral Service Que Thomas Grego	ty Of Mary oad Baltim	land Inc. ore, Mary	<u>land</u> 21	228						
68760, -	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if ally, leading to infinite date.									Due	Onset	kmate al Between and Death	
P.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	,		23d. Date Mont		Year	
Ś	puires that i n signed by ild be deta	þ	Part II. Other significant condition	s contributing to death t	out not resultin	ng in the u	nderlying cause giv	en in Part I.		I tobacco use contrib	oute to the cause		
Record	The law requires that the rate has been signed by the page 2 should be detache	Completed						***	24a. We aut per	opsy pri formed? de	ere autopsy find or to completion ath? Yes 2 \(\subseteq \text{No.}	n of cause of	
of Vital	Physician: Th this certificate ral director, pag	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER	VOutpatier	nt 3 DOA Oth	0.00	of Death (Check only		(Specify)		
Division of	ttending death. stor: After the fune	Certification; T	27. Manner of Death 1 XNatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In		Bb. Time o Injury e, farm, str	Wor		No 28d. Describe	e how injury occurre (Street and Number own, State)	d	Number,	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and manner s	of examination	edge, deat n and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, and due to the	e cause(s) and man e, date and place, ar	ner as stated. Id due to the cal	use(s)	
	To the vithing to the complex	×	29b. Signature and title of certifier	Mar			29c. Licens		64	29d. Date signed			
_	2		30. Name and address of person w	tAS Hmi	821	N.	Print)	2 42	6 4 mte 305	, Balt	more "	MD 212	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 5	2005	rar's Signatur	e X	beels)						

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death		E 0 0 0	01626
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	hysicia		Elmer Leroy Corns, Jr.	Anuac	Day Year и 22 2005	3:34 PM
	Medic/ Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	7	4c. County of Death	
			St. Hanes Healthcare Baltimore			
	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr 21.7 5.2 26.5.2 1 ☑ M 2 ☐ F 5.7 Yrs. Months Days Hours Mir	. (Month, Da	th 9. Birth	nplace (State or Foreign untry)
	rector		217-52-2653 180 2 57 Yrs. Usual Residence of Decedent	Nov. 24	+,194/ Mary	land
yland	Mot	Ì	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ө Ма	la-fa	cto	Maryland Baltimore Arbutus			1 ☐ Yes 2ÃÃNo
Ath th	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	intry?
eath v	18 238 Trust	eral	4721 Benson Avenue 21227 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Ves or No	U.S.A.	ican Indian
fer de	Inaci	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 S 2 No	rto Rican, etc.)	Black, White	
036	Enar.	۵	3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify: Wh	ite
21215-0036 ad within 72 hours aff	dical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	orking	16b. Kind of Business/I	ndustry
121 Mithin	then a	mpl	Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver		Refuse	
H G G G G G G G G G G G G G G G G G G G	ther in			am <i>e (First, Middle</i>	, Maiden Surname)	
la be	ked o	To Be	Elmer Leroy Corns, Sr. Mary F	Beatrice	Healey	
Maryland Id 2 should be file th and Mental Hy	amar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or It	Rural Route Numb	er, City or Town, State, Z	p Code)
Mand 2	n 27 l ler tre		Timothy C. Corns, Sr. (Son) 1124 Ingleside Avenue		imore, Mary	
ore 1 ges 1	If iter or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemeters, ce	Date	20c. Location - City or 1	own, State
Baltimore, permit. Pages 1 a	rtant: njury		'4 □ Donation 5 □ Other (Specify) Gardens 1 − 2 21. Signature of Funeral Service License e 22. Name and Address of Facility	27-05	Marriottsvi	lle, MD
Bal Permi	Important: If item 27 Is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar mast be notified at once.		Witzke Funeral Hor 1630 Edmondson Ave	ne of Cat	onsville, I onsville, MD	nc 21228
			23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death) a. Atheroscieratic Cardiovas	cular I	9229216	yews
	edical ıminer		Due to (or as a consequence of):			
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o o	ian an irial-tr		resulting in death) Last Due to (or as a consequence of):			
68760 ificate be e	physician and the burial-transit	dical	d			
	ding p	e e	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	uani
eath B C	attending p I for use as	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month	Day Year
P.O.	by the	hysl	1 Yes 2 No 9 Unknown	200		2010
-	signed by the atte d be detached for	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	tobacco use contribute to	the cause of death?
ords, requires	been sig should b			10	Yes 2 No 3 Pro	obably 4 Onknown
1 11 >	as be	Completed		24a. Was auto	psy prior to c	topsy findings available ompletion of cause of
7	page,	Con		1 ☐ Yes	ormed? death? 2 No 1 Yes	2 □ No
E D Physicien:	certifi	Be	examiner?	eath (Check only		
_	or this aral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		idence 6 Other (Spec how injury occurred	(fy)
Vision Attending	r: Afte e func	atlor	Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division lor Attending	recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Number or Ru wn, State)	ral Route Number,
	led in					
Division of Attention of Attent	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) Medical Examiner: On the bast of my knowledge, death occurred at the time, date and pla (Check only one) Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and pla (Check only one)			
o the	ro the	Me	29b. Signatule and title Pertifier 29c. License number		29d. Date signed (Month	, Day, Year)
	1		Attending Physician D5/85	3	Janvary 2	2,2005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Janvary 2 Himace	21225
	(Michael Silverna 900 Corton Aven. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ie ba	TIMACE	416
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2 Date of Death Month Day 01/22/2005 4b City Town or Location of Death 4c. County of Death Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/19/1932 7. Age (In yrs. last birthday) Months Days Hours Min. 1 ☐ M 2 🖪 F Yrs. 72 PA10c. City. Town or Location 10b. County Pasadena 10g. Citizen of What Country? 10f. Zip Code

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:50AM Marian E. Cherry /Medical 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 203-24-8316 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 28a-f shov other traumatic event, the Madical Examiner must be nutilised at 1 ☐ Yes 2 No Director Anne Arundel 10e. Street and Number 5 Items 23a 21122 U.S.A. Completed by Funeral 156 Dunlap Road death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. I and 2 should be filed within 72 hours after teath and Mental Hygiene. om 27 is marked other than "natural", or Itei 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 M Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Tavern Owner Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Buser Grace Welty 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health in Item 27 I Deborah Elliott/Daughter 156 Dunlap Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1 ☐ Burial 2 II Cremation 3 ☐ Removal from State Bayview Crematory 01/24/05 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death mmediate Cause (Final Priysician disease or condition resulting in death) CEREBROVASCULAR ACCUDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Kunknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**4** No 2 No 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 ☐ Yes 2 X No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural
2 ☐ Accident after death. Director: A 2 No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai

law requires that the death certificate be executed Physician:

Box 68760. P.0. Records, Vital of Division Hospital or Attending filled in by 24 hours a completely within 2 To the

Registrar

DHMH 17 Rev 1/2001

TARIQ MAHMOOD

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State o	f Maryl	-	artment rtificate			Mental Hy	/giene	105	01628
	Physici		Decedent's Name (First, Middle James Warre	_{le, Last)} n Collins	5					2. Date of D Month AーNは	D	2005	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution	n, give street and nur		TAL	4b. City, To		Location of Dea	th	4c. County of Death ANHE A		
	Funeral Director		5. Social Security Number 220-03-5604	6. Sex 1 → M 2 □ F		yrs. last birthday,	If Under 1 Months (Hours Min		irth la <i>y, Year)</i> 3 , 1921	9. Birtho Coul MD	place (State or Foreign htry)
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c.	. City, Town or L	ocation						10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow rmust be calified at	ecto	MD Anne	Arundel		Sever	n 10f. Zip C	ode.			10g. Citizen	of What Cou	1 ☐ Yes 2 No
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215-	within 72 lene. than "nat	Completed by		nt's Education est grade completed) College (1	I-4or 5+)	(Give		done di retired)	tion uring most of wo	orking		f Business/In	,
$\langle \zeta \rangle$	filed wi Hygien other th	Con	12 17. Father's Name (First, Middle,	Last)		Mai.	1 Handl		18. Mother's Na	ıme (First, Middle		Offic	e
Jana	uld be Mental rked o	To Be	Charles Colli						Christ		NKNOWN)	,	
Maryl	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Negace.		19a. Informant's Name/Relations Mr. Thomas J.		riand					Rural Route Numb Baltimon			
e S	es 1 and of Health of Item 27 ir other to	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20	b. Place of Dispo cemetery, cre	osition (Name	of		Date		on - City or To	
A AW	it. Peges intment of intent: If It injury or o		*4 Donation 5 Other (S	Specify)	M	leadowri	dge Men					dge, M	
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	S (c)		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	t only one cause on e	ach line.	death. Do not en					arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Dog to (or as a con	sequence of):		-	1 7314	d Colin			
	E	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D		sequence of):							
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Box 68	aath certifica attending ph for use as th		IF FEMALE:	23c. If yes, out	come of pre	eonancv					224	Date of delive	20/
P.O. Bo	D 00	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 F eant at time own		□Ectopic preg □ Other (spec					Month	Day Year
	requires that been signed k	by	Part II. Other significant conditi	ons contributing to de	eath but not	resulting in the u	inderlying cau	ise give	n in Part I.		tobacco use co Yes 2 □ No		ne cause of death?
Division of Vital Records,	he law requ e has been age 2 shoulk	Completed						_			ormed?	prior to co death?	psy findings available mpletion of cause of
ital	ding Physician: The Ih. h. After this certificate ha funeral director, page	Be Co	25. Was case referred to medica examiner?	II.					26. Place of De	1 ☐ Yes eath (Check only	2 No one)	1 🗌 Yes	2 D No
of C	Physic this ce	은	1 Yes 2 No			2 ER/Outpatie			4 Nursing	Home 5 ☐ Res	how injury occ		y)
ion	uttending F death. ctor: After y the funer	ation	1 ■Matural 5 Pendir 2 □ Accident investi	igation	of Injury th, Day Yea	r) Injury	М 200	C. Injury Work 1 □ Y	es 2 No	Zod. Describe	now injury occ	201190	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place	of Injury - Ang, etc. (Sp	At home, farm, st ecify)	reet, factory, o	office		28f. Location City or To	(Street and Nu wn, State)	mber or Rura	I Route Number,
	24 hospit 24 hours Funere	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the Examiner: On the ba	best of my asis of exan ner stated.	knowledge, deat nination and/or in	h occurred at ivestigation, in	the time	e, date and plac nion, death occ	e, and due to the surred at the time	cause(s) and date and plac	manner as si	tated. the cause(s)
	To the To the compl	Me	29b. Signature and title of certific	<i>y</i>		mn	29c. L		number 5146		29d. Date sig		·
	<u> </u>		30. Name and address of person	who only caus		(Item 23a) (Type,	Prings		AL	0	Janus	7	2 2005
/.	//)		31. Date filed (Month, Day, Year,	0 501		sprotal	NY.	ve	ale	en 100	rnie	mi	> 21061
1	Sta Registr		IAN 2 5 2	2	ada a	11. Ana	1/10						

State of Maryland / Department of Health and Mental Hygien For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Frank Cyhanick Joseph 19 2005 6:10 Рм /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth 12/12/1923 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 215-16-9644 81 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland anent of Health and Mental hygiene. ansi: if Item 27 is marked other than "natural", or Items 238 or 28a-f show ant: if Item 27 is marked other than "natural", or hier transat lear reliated at ury or other traumatic event. Ite Medical Exerting the reliated at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State MD Anne Arundel Severn 1 ☐Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 1174 Reece Road 21114 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white Specify. 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Boilermaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Cyhanick Anna Obshud 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trau once. Mrs. Carol A. VanAlstine/child 1229 Reece Road, Severn, MD 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/24/05 Brooklyn, MD Holy Cross Cemetery 4 □ Donation 5 □ Other (Specify) 2 Signature × Funeral S vice Lowisee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave SW Glen Burnie, MD 21061 M01364 16 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 160m021 Physician 1080C disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit 5 that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Dunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 2 No 1 □ Yas 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 his 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: To the Hospital or Attending I within 24 hours efter death.

To the Funeral Director: After 1 Waturai 5 Pending investigation М 1 Tyes 2 □ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's signature 31. Date filed (Month, Day, Year) 5150 State Registrar

			For State Registrar	State of Ma	aryland / Depa	artment of F rtificate of I	lealth and Me Death	ental Hygier Reg.		01630
	Physici	an	1. Decedent's Name (First, Middle,				2	2. Date of Death Month	Day Yes	3. Time of Death
1	/Medic	cal	EDWARD A. CICH			4h City Town o	r Location of Death	JANUARY 2, 2006 05:00A 4c. County of Death		
	Examin	ner	6000 GAMARIT	AN HOSDI	TAL	BALTI	MORE		NA	o au i
	Funeral		5. Social Security Number 6		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Ye	ar) 9.1	Birthplace (State or Foreign Country)
	Director		217-07-2438	X □M 2□F	88 Yrs.	Months Days	Tiodio Iviii.	4/8/1916	M	ARYLAND
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	B-1 sh	tor	MD BALTIN	10RE	ESSEX					1 ☐ Yes 2 ☐XNo
	iff the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
	a 23a	rai	1200 APPARITION		Funcia II C. 112	21220	04-1-2/0		USA	merican Indian.
10	ther de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give		f Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto Ri	can, etc.)	Black, W	
036	rai', o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or itema 23e or 28a-f show ita Madical Exar it at mast be indiffied at	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup kind of work done	during most of working	16b	. Kind of Busine	ss/Industry
12	withir ene. than	дшс	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired	1)	S'	TEEL FAC	CTORY
	e filed I Hygi other	Be Co	12TH GRADE 17. Father's Name (First, Middle, La	st)	STEE	EL WORKER	18. Mother's Name (
/lar	Menta Menta arked atic sy	To E	JAMES CICHOCK				HELEN RA	CKUBA		
Maryland	12 should be filed within 7 and Mental Hygiene. 7 is marked other than "raumatic svent, Ita Med		19a. Informant's Name/Relationship				and Number or Rural			a, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-1 show other traumatic svent, its Medical Era in at must be indiffied at		EDWARD F. CICHO 20a. Method of Disposition	CKI SO	20b. Place of Dispo		Da	ALTIMORE 20c.	MD 2. Location - City	1220 or Town, State
ē	Pages nent of I ant: If Its ary or o		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		METRO CRE	natory or other plac MATORY	· I		ATONSVII	
Baltimore,	permit. Pages 1 and 2. Department of Health at Important: If Item 27 Is any injury or other trau		21. Signature of Funeral Service Lie	_						HOME, P.A.
_	8258		12				RAVEN BLVD		N, MD 2	21286
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	mplications that caused ly one cause on each li	the death. Do not ent ne.		ig, such as cardiac or	respiratory arrest,	ا نس	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. HYPEKO	a consequence of):	RESPI	RATORY	FALLUR	Œ	
	Examiner			SEVER	E AGPIRA	ATION	PNEUMO	NIA		
-	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	1 7 4 7 1	0.01			
1-6-	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CHKONI	a consequence of):	-11A11	UN		<u>-</u>	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		POOR	NUTRITI	ONAL S	STATUS			
9	tificate ig physi as the b	ledic		0.						
Вох	that the death certifics ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy			23d. Date of e	delivery Day Year
_	the all	ysic	1 Yes 2 No	4☐ Pregnant a 9☐ Unknown	t time of death 5	Other (specify)			Month	Day Tour
, P.O.	uires that the signed by Id be detac	y Ph	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
rds	w requires been sign should be	ed b	SYSTOLIC CA	RDIDMY	OPATHY			1 🗆 Yes	2 □ No 3 □	Probably 4 Dhknown
eco	e law requ has been ge 2 should	Completed by						24a. Was an autopsy	prior t	autopsy findings available to completion of cause of
a R	cate h							performed 1 □ Yes 2		
V.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ☐ ER/Outpatier	oth	er: 4 Dayseign Hams		6 Float /6	
l of	ding Phys	n: To	27. Manner of Death	1 V Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time of		y at 28	5 ☐ Residence d. Describe how in		pecity)
sior	Attendin death. ctor; Aft y the fur	catio	1 Natural 5 Pending 2 Accident investiga	ion	y roary inquiy		Yes 2 □No			
Division of Vital Records,	after di Direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide 6 ☐ Could no		ury - At home, farm, str c. (Specify)	eet, factory, office	28	f. Location (Street City or Town, St.	and Number or ate)	Rural Route Number,
	spital cours a neral		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, deatl	n occurred at the tin	ne, date and place, an	d due to the cause	(s) and manner	as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical E)	aminer: On the basis o and manner st	f examination and/or in	vestigation, in my o	pinion, death occurred	at the time, date a	and place, and d	lue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	ka Now		29c. Licens	e number	29d. I	Date signed (Mo	onth, Day, Year)
,			/ /wy av		1 - 1 /h	KE90	W	DA	NUARY	169,6000
	6+1		PRIVANKA GOI	N M D	leath (Item 23a) (Type, 500 LOV ar's Signature	HRAVE	NBLVD	BALT	IMORE	MD 21239
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 5	2005	we Be d	backs				

State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 12:35AM MAKCARET JAN 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PALTIMORE BAYVIEW MEDICATE CENTER HOPKINS N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 K F 94 SEPT. 8,1910 212-01-3517 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural, or itame 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Funeral Director N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3713 FOSTER AVENUE 21224 U.S.A. 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify. Completed by 3 XWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) TYPIST ADVERTISING CO. 8 Ith and Mental Hyor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **JOHN** WANGER CRESCENTIA **ADELMAN** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health ar item 27 is KATHLEEN CASEY/DAUGHTER 3713 FOSTER AVENUE, BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h permit. Pages Department of Important; if it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 1/27/05 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sepvice Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING ST., BALTO., MD. 2 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBAR **Physician** DAYJ /Medical Due to (or as a consequence of): Examiner IN FLUENZ WEFK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be FISRILLA TION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown STRIKES Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No It'S PERCHOLE STEROLEMIA HYPERTENSION, 24a. Was an autopsy performed? Yes 24 No REFLUX DISEASE GASMO - ESOPHAGETE 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Tripatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director; 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, BALTIMORE, MD EMMANUEL ANTONARAKIS 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DUKES, ELBERT 05-00357 LEW

			For State	State of Maryland /	-	artment of He tificate of D			2005	01632			
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of L	caur	2. Date of Death	. No.	3. Time of Death			
	Physici		Elbert u	2 Dukes				January	Day Year 15, 2005	4:55 A.M			
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or I	Location of Death		4c. County of Dea				
			SINAI HOSPITAL			BALTIM		·	NA				
	Funeral Director		5. Social Security Number 6. Sex 19	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bir	thplace (State or Foreign			
			Usual Residence of Decedent					1-3-	(778 We	st Virginia			
	with the Maryland a or 28a-f show the notified at	<u>.</u>	10a. State 10b. County	10c. City, To					10d. Inside City I				
	8a-f	ecto	red N/A	Dal	him	Ure				1 ⊠Yes 2 No			
	with t	Dir	10e. Street and Number	Au.		10f. Zip Code 2/2	1	109	Citizen of What Co				
	death ma 23 r must	Funeral Director	5/12 Ne/80	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban		ecify Yes or No-	14. Race - Ame	erican Indian,			
215-0036	or its	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Specify:	Hican, etc.)	Specify: 13							
5-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	cation 16 completed)	a. Deced	dent's Usual Occupation of work done do NOT use retired)	tion uring most of work	ing 16	b. Kind of Business	/Industry			
121	d within giene. rr than "	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	Λ	/ / .			so had				
d 21	D D = -	a	17. Father's Name (First, Middle, Last)		Lus	1		e (First, Middle, Ma	iden Sumame)				
<u>la</u> n	should be filed and Mental Hygi marked other matic event,	To B	Charles L	Jukes			Mildr	ed Tens	on				
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Ty)		9b. Mailin	g Address (Street ar	nd Number or Rui	al Route Number, C	ity or Town, State,	Zip Code)			
	1 end Heelth em 27 ther tr		Arlethia Simm		5115	Sition (Name of	Ave	Ballo . ly	1. 212/1	To a Sum			
Baltimore,	Page nent o ent: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	tery, cren	natory`or other place)	Date 20	c. Location - City or	Town, State			
Ħ			 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	Gree	nmo	. Name and Address	ory Jan	28, 2005 1	1 Service	01			
Ba	Departi Importi eny inji		Carlon C.	Dunfan	C	701 McCu	Hoh St.	Balb.	ud. 2/21;	7			
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do	o not ente	er the mode of dying	, such as cardiac	or respiratory arrest	,	Approximate Interval Between			
	Pnysician		Immediate Cause (Final disease or condition	Head and	N	ock 7	ugen	(م)		Onset and Death			
1	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):		0						
	N. S.	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):								
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0,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):								
8760	icate be ex physician s the burial	dical											
4		a)	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy					23d. Date of de	livery			
. Box	death certif e attending ed for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death		lEctopic pregnancy] Other (specify)			Month	Day Year			
P.0	by the	hys	9 🗆 Unknown	9□ Unknown									
	requires that the de been signed by the a hould be detached f	by	Part II. Dther significant conditions con	tributing to death but not resulting	in the ur	nderlying cause giver	n in Part I.			the cause of death?			
ord	requi	eted								robably 4 Unknown			
of Vital Records,	has by	Completed						24a. Was an autopsy performe	d? 24b. Were at prior to death?	utopsy findings available completion of cause of			
al		e Co	25. Was case referred to medical				00 Plane of Pare	1 X Yes 2		2 □ No			
<u> </u>	S S =	0 8	examiner?	lospital: 1 ☐ Inpatient 2 X ER/0	Dutpatien	Out		h <i>(Check only</i> one) ome 5 □ Residend	e 6 □Other (Spe	cify)			
0	ding Ph. After thi funeral	n: T	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	. Time of	28c. Injury Work		28d. Describe how	injury occurred	Jan String			
Sio	Attending or death.	catic	Accident investigation Suicide 6 Could not be	1-15-05 4	1:15	4 M 1□Y	es 2 No	vecare	e ^d	2000-5			
Division	를 를 들는	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		eet, factory, office				Beaufirt Aul.			
البسط	Hospitel		29a. Certifier 1☐ Certifying Phys	sician: To the best of my knowled	ge, death	occurred at the time	e, date and place,	and due to the caus	se(s) and manner as	Z1Z15 s stated.			
	the Ho hin 24 h the Fu npletely	Medical	(Check only 2 Madicel Examir one)	ner: On the basis of examination a and manner stated.	and/or inv	estigation, in my opi	nion, death occur	red at the time, date	and place, and due	e to the cause(s)			
	To t To t	Σ	29b. Signature and title of certifier	10/1/1		29c. License			. Date signed (Mont				
			THING	VVVI	\	O.C.M.	L.	Jai	nuary 15,	2003			
	7		30. Name and address of person who co	mpleted cause of death (Item 23a	i) (iype,	111 PENN	STREET	BALTIMOR	E, MARYLA	ND 21201			
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	k /	Jane 1			•				
	Registi	ar	JAN 2 5 2	005 Jalence L	1								

		1- For Amend Item 23state of Maryland, Department of Health and Medical Performance of Death	ental Hygie	2005 01633
Physic /Med			2. Date of Death Month	Day Year 3.15 M
Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 18	8. Date of Birth A (Month, Day, Y	BALTIMORE 9. Birthplace (State or Foreign
Directo		214-26-5416 27 83	April 22,	1921 Mary and
yland sow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
e Mar Sa-fsh	ctor	Ad N/A Baltimore		1 Styles 2 No
with th	Funeral Director	501 & Preston St. 715 21202	10g	Citizen of What Country?
death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Security Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian, Black, White, etc.
1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 1 Yes 250 No If Yes, Give 1 Yes 250 No Specify: Year or Dates:	100.7	Specify: Black
21215-0036 ad within 72 hours af giene. er then "naturel; or i. the Medical Exam.	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16	b. Kind of Business/Industry
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d 2	Be Co	7 House Kelpl v 17. Father's Name (First, Middle, Lagt) 18. Mother's Name ((First, Middle, Ma	(120, Ca) iden Sumame)
arylanoshould be nd Mental s marked o	To B	Daniel Dunnock Lillian	Mye	y S
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show many injury or other treumetic event. The Medical Examinar must be notified at	ş	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 10 Toleal Ct. Rand	1 1/1	10
ore, Mass 1 and 2 of Health at item 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition Date of Date of Disposition Date of Dat	ate 20	c. Location - City or Town, State
Baltimore, Department of Hee Importent: If item		14 Donation 5 Other (Specify) Mt. Zion Cemetery Jan. 2	r, 2005-1	Palp led.
Baltimore permit. Pages: Department of the Importent: If ite		21. Signature of Funeral Service Licensee 22. Name and Addres of Facility Court fon C. Dougles. 1701 UcCulloh St.	funer Bolds	nd Service P.A.
t		23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Atherosclerotic Heart	respiratory arrest	Approximate Interval Between
Physiciai /Medica		Immediate Cause (Final disease or condition resulting in death)		Onset and Death
Examine		Due to (or as a consequence of):		
sit 8d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
execut n and ial-tran	Examiner	that initiated events c. Pue to (or as a consequence of):		
I Records, P.O. Box 68760, — The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d		
Box 68 leath certific: attending pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of delivery
D. BC s death he atter	Physician/Med	in the past 12 movins? 1 Yes 2 No 1 Yes 2 No		Month Day Year
IS, P.O. I res that the de signed by the a		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobad	cco use contribute to the cause of death2
rds, quires in n signe	ed by			2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Records, he law requires t e has been signe age 2 should be o	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
				d? death? No 1 Yes 2 No
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vision of Vita Attending Physicien: r death. ector: After this certific by the funeral director,		27. Manny of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 (Month, Day Year) Injury Work?	8d. Describe how	
Division If or Attending after death. Director: After din by the fune	licat	2 Accident investigation M 1 Yes 2 No	8f. Location (Stree	at and Number or Rural Route Number,
Div	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, S	
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	cal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date	and place, and due to the cause(s)
To th withir To th	Me	29b. Signature and title of settler 29c. License number	29d	Date signed (Month, Day, Year)
		20. Name and address of parson who completed eause of death (flow 22a) (Time Paint)	7.	ANNARY 25 2005
2		LEONARD RICHARDSON M.P. S 602 BALTIMORE NATIONAL PIKE &	#603 BAL	TWORE MD 21228
S Regis	tate trar	and manner stated. 29b. Signature and title of periffer 29c. License number 29c. License n		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 19 2005 10:o7a M DAVIS **JAMES** /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2100 Madison Strret Baltimore NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 79 Director 215-40-2938 12-25-25 N.C. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iraf, or items 23a or 28e-f show X□Yes 2□No Director Baltimore Md. NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21217 2100 Madison Ave. Apt. 101 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify: Black à "naturaf", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 7th grade Laborer and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Davis Wilma Gaither 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum once. 2913 Echodale Ave., Baltimore, Md. Alicia Evans Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 1-29-05 Lansdowne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 la I ame 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MYOLDRDIAL NTARCITON **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** YPERDENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 1 No Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Anaturel 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) and manner stated.

**To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 30. Name and address of rson who completed callse of death (Item 23a) (Type, Print) BAUTIMORE AXJO 9 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

ORIGINAL

			1 - For State Registrar	State of I	Marylar		artmen tificat			and M		giene.	20() 5	016	535
	Physici	an.	Decedent's Name (First, Middle,								2. Date of Dea	Dave		Year	3. Time of	f Death
	/Media	cal	Monique B. Dy								January				4:05	Ам
	Examir	ner	4a. Facility Name (If not institution,		er)				Location o	of Death			County o			
	Formul		6733 Groveleigh 5. Social Security Number		Age (In vrs.	last birthday)		olum 1 Year		24 Hrs.	8. Date of Birt		Howa		place (State o	or Foreign
п	Funeral Director		442-34-8636	1□M 2ᡚF	70	Yrs.	Months	Days	Hours	Min.	(Month, Da July 20	/ Yearl	4	Frai	olace (State ontry)	or r or ergin
	<u> </u>		Usual Residence of Decedent													
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	10d. Inside C	
	Ba-f	Director	Maryland Howa	rd		Co1um									1 🗌 Yes	2 K 140
	with a or 3	ō	10e. Street and Number 6733 Grove1	eich Drive			10f. Zip		1046			10g. Citiz T	J.S.A		ntry?	
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9	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or items 23a or 28a-1 show event, the Medical Examinar must be notified at	F	1 ☐ Never Married 2X Marrie	Armed Force d 1 ☐ Yes 2[s?	1				, Puerto	ecify Yes or No- Rican, etc.)	İ		, White,		
03	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		⊺□Yes :	2€ No	Specify:				Specify:	Whi	te	
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Maryland 21215-0036	2 should be f and Mental H Is marked of aumatic ever	_	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address	(Street a	and Numbe	or Or Run	al Route Numbe	r, City or	Town, S	tate, Zip	Code)	
	2 = Z		Norman C. Dyer	(Husband)					gh Dr	ive	Columb	ia,	Mary	1an	d 2104	6
ore	00		20a. Method of Disposition 1 Burial 2 □ Cremation 3	t ⊟Removal from Sta	20b. F	Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther place	θ)		Date	20c. Loc	ation - C	ity or To	own, State	
Ë	Pag ent nt: I		* 4 ☐ Donation 5 ☐ Other (Spe	ecify)	St.		-				-2005		svil	1e,	Maryl	and.
Baltimore,	permit. Departm Importa any inju		21. Signature of Fineral Service Li	censee	1	W:	. Name an itzke	d Addres Fun	s of Facility eral	y Home	es, Inc.					
	402.00		23a Part 1 Enter the disease or co	omplications that cause	and the deat						oad Colu		, Ma	ry1		
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Вох	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23	3d. Date	of delive	erv	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth	at time of d		Ectopic pro Other (sp						Monti			Year
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ion	Attending I r death. ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		Jay Year)	Injury	М		:? /es 2 □ N	No						
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	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1⊠ Certifying (Check only one) 1⊠ Medical Ex	Physician: To the be eminer: On the basis and manner	of examina	wledge, death tion and/or inv	occurred a estigation,	at the tim- in my op	e, date and inion, deat	d place, a	and due to the c ed at the time, c	ause(s) a late and p	ind manr place, an	ner as st d due to	ated. the cause(s)
	To th withir To th comp	Ž	29b. Signature and title of certifier	-10			29c	License	number		2	9d. Date	signed (Month,	Day, Year)	
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	10		30. Name and address of person wi													
	Y		Andrew Tyler I 31. Date filed (Month, Day, Year)			Reser		Road	l, NW	Wa	shington	n, DO	200	007		
	Sta Registr		IAN 2 5 200	732. Regi:	, Jan S Signa	Sport	D.									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 January 19, 4:30 PM **EDNA** DORSEY /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner McCready Memorial Hospital Somerset Crisfield If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 28, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 3, 1916 Crisfield Months Days Hours 1 □ M 2 耳 F Yrs 88 Director 215-05-8935 Usuat Residence of Decedent pernit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mentel hygiens. Important: If Item 27 is marked other than "nature!" or items 23e or 28e-f show any Injury or other treumstic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Crisfield Somerset 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3457 State Street 21817 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Maritat Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White δ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Melissa Ward Sidney O. Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell S. Landon (Nephew) 2800 Woodley Road, NW Art. 415 - Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/05 Crisfield, Maryland Asbury Cemetery 22. Name and Address of Facility
Bradshaw & Sons Funeral Home Mary Beth Bradshaw -Pruitt 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Attending Physicisn: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2√ No 1 Yes SEPSIS Be Completed by ate has been signe pege 2 should be 24b. Were autopsy findings available prior to PANCREATITIS. 24a. Was an autopsy performed? completion of cause of death? 1 Yas 25 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospitat: 1 √ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred J or Attending s after deeth. J Director: Aft ied in by the fu 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, tarm, street, factory, office building, etc. (Specify) 4 I Homicide filled in To the Hospital within 24 hours a To the Funeral C completely filled 123 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D 48098 19/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year)

JAN 2 5 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LAWRENCE L. DYPSKY JAN 19 2005 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSSVILLE BALTIMORE MANOR CARE-ROSSVILLE Date of Birth (Month, Day, Year)
AUG. 8,1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** XX M 2 F 217~09~8706 84 Yrs Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "natural", or itama 23s or 28s-f show the Madical Examiner must be notified at 10d Inside City Limits Baltimore County Maryland Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 6707 Beech Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. X1X Yes 2 No
If Yes, Give
Year or Dates: WW 11 1 Never Married X2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CXNo Specify Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Welder 6th grade other 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Catherine Dudeck Julius Dypsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6707 Beech Avenue Baltimore, Maryland Dorothy A. Dypsky (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley M. G. 1-22-2005 Baltimore, Md. *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Funeral Home Lassahn 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** Dementip /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the at d be detached fo 4 Pregnant at time of death o 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 CUnknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) s certificate has t lirector, page 2 s autopsy 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Tes 2 No Certification; To 3□ DOA Nursing Home 5 Residence 6 Other (Specify) After thi 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of Injury injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53462 WD 120/05 s of person who completed cause of death (Item 23a) (Type, Print) JAHWOOD ROAD Glen Burnie, mD 21061 Muneses MA 7845 Jude 31. Date filod (Month, Day, Year) 32. Registrar's Signature State JAN 2 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien (2)

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State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** 19. 6:26 Dominique Jan. 2005 Yvonne Cadet /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park Date of Birth (Month, Day, Year) Jan. 13, 1934 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Haiti 1 M 2 TVF 71 Director 088-70-4715 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Exac direct hand be notified at 1 Yes 2 No MD Takoma Park Montgomery Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number ö 20912 United States 7620 Maple Avenue 238 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (MNo If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2X Married **Black** 1 ☐ Yes 2 → No Specify: Baltimore, Maryland 21215-0036 ō Specify: þ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Sewing than College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. other than Seamstress 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hisant: If Itam 27 is marked out Cadet Cadet Mary Valentine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3110 Whispering Pines Drive, SilverSpring, MD 20906 Whitney Dominique/Daughter othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20 Department of Important: If any injury or once. 1/26/05 Beltsville, MD Chesapeake Crematory ⁴ □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD Pet1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 DAY disease or condition resulting in death) Q SIC /Medical Due to (or as a o insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai the as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the hed f o 9 Unknown signed by the Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 280 No certificate Division of Vital or Attanding Physician: 26. Place of Death | Check only one Be 25. Was case referred to medical examiner? Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient ٩ 1 ☐ Yes 2 X No this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. 27. Manner of Death Injury at Work? Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide o the Hospital 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier CI 45660 30. Name and address of person who completed cause of death (Ite-23a) (Type Print) 0 SA (-) (300 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 5 2005 Registrar

			. For	State	of Maryland				and Mental	Hygieme	005	01640	
		-	State Registrar			Cei	rtificate of	Death		Reg. No.		01010	
	Dharist		1. Decedent's Name (First, Middle	, Last)					2. Date o	Day		3. Time of Death	
	Physicia /Medic		GENEVIEVE	LUCILLE	DAMIAN	0			Janu		, 2005	10:05 A. [™]	
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town,		of Death		County of Deat		
			HCR-Manor Care		7 4 (10 10	at hidhdoul	Towso		24 Hrs 9 Date of	Baltimore Hrs. 8. Date of Birth 9. Birthplace (State or Foreign			
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs. Ia	Yrs.	Months Days		Min. June	, Day, Year)	Co	Cyland	
	Director	}	212-20-0311 Usual Residence of Decedent		11				June	47, 19	27 2202	- 	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	Man, -fsh Iled	to	Maryland Balt	imore		Parkv	ille					1 ☐ Yes 2 🔀 No	
	r 28s	Directo	10e. Street and Number				10f. Zip Code			10g. Cîti	zen of What Co	untry?	
	death with the Maryland rms 23a or 28a-f show		1863 Edgewood	Road			21	_234			U.S.A.		
	deal deal	Funeral	11. Marital Status	12. Was De Armed F	ecedent Ever in U.S Forces?	3. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica	rigin? (Specify Yes on, Puerto Rican, etc		 14. Race - Ame Black, White 		
õ	or lt		1 Never Married 2 Marri	11 1 95, 0	s 2 XNo Give		1 □ Yes 🌠 N	o Specify	:		Specify: Talb	ite	
215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or Items 23a or 28a-f show other than "naturel", or Items 23a or 28a-f show event. Ite Medical Examination matter multiply at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or	Dates:	16a Daca	dent's Usual Occ	unation		16b Ki	nd of Business/		
င်	"nat	Completed	15. Decedent (Specify only highes	t grade completed		(Give	kind of work don DO NOT use retii	e during mo:	st of working	100.74		,	
12	within 72 ene. than "na	mc	Elementary/Secondary (0-12) 12 years	College	(1-4or 5+)		Waitress	5			Restaur	ant	
0	filed Hygie other	Be C	17. Father's Name (First, Middle,	Last)	'			18. Moth	er's Name (First, Mi	ddle, Maiden	Surname)		
au		To B	Jerry	Damian	0			Jos	ephine		Oliver		
Maryland	2 should be and Menta is marked aumatic ev	_	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Stree	et and Numb	er or Rural Route N	umber, City o	r Town, State, 2	Zîp Code)	
	# # #		Robert T. Wood	s, III	(son)		Edgewood						
ore	of Hea of Hea fitem		20a. Method of Disposition 1 Burial 2 Cremation	3 DRemoval from	20b. PI	ace of Dispo metery, cre	osition (Name of matory or other p	lace)	Date	20c. Lo	cation - City or	Town, State	
Ĕ	Pages nent of ant: If it ury or o		' 4 ☐ Donation 5 🙀 Other (S	oecify) Enton	nbment Mo		Ly Redee		1-26-05			Maryland	
Baltimore,	pernit. Pages Deportment of Important: If i any injury or o		21. Signature of Funeral Service	_icensee		2	Name and Add	ress of Facil -Wiede	efeld Fune	ral Ho	me. Inc	langerousen	
_	<u> </u>		Thorne (re	nane			6500 Yo	rk Roa	ad <u>Baltın</u>	ore, M	larýlano	21212 Approximate	
E			23a. Part1. Enter the disease, or shock, or heart follure. List	complications that only one cause or	it caused the death n each line.	. Do not en	ter the mode of d	ying, such as	s cardiac or respirati	ory arrest,		Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	coron	ary	arter	y di	sease			20 years	
	/Medical Examiner		resulting in death)	Due t	to (or as a consequ	ience 🍂):						Ü	
		-	Sequentially list conditions,	b. — Due t	to (or as a consequ	ence of):		_					
Т	nsit	를	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								~		
Ć.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due t	to (or as a consequ	ence of):							
760,	eath certificate be executed attending physician and for use as the burial-transit	cal		d									
89													
Вох	th cer endir r use	an/	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna- e birth 2 Fetal		□Ectopic pregnar	псу			23d. Date of del Month	livery Day Year	
о. Ш	that the death ed by the atte detached for	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□ Uni	egnant at time of de known	eath 5	Other (specify)			_			
<u>Ч</u>	at the	Phy	Part II. Other significant condition	ans contribution to	n death but not resu	ulting in the u	inderlying cause	niven in Part	I. 23e.	Did tobacco u	ise contribute to	the cause of death?	
JS,	se us es	l by	end stag	e lein	untia			3		1 ☐ Yes 2	□No 3□Pr	robably 4 Unknown	
000	w requir been si should	etec	8						242	Was an	24h Were at	utopsy findings available	
3ec	has has	Completed								autopsy performed?_	prior to death?	completion of cause of	
Vital Record		e Co	25. Was case referred to medica					26 Plac	e of Death (Check		1 L Yes	22No	
₹	Physicien: this certific ral director,	To Be	examiner?	Hospital:	□Inpatient 2□	ER/Outpatie	nt 3 DOA	N	Jursing Home 5		6 □Other (Spe	ocify)	
of	Physer this eral di		27. Manner of Death	28a. Da	ate of Injury fonth, Day Year)	28b. Time o		jury at	28d. Desc	ribe how inju	y occurred		
ion	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pendir 2 Accident investi	. 9	ionin, Day 16ar)	mjury		☐Yes 2☐	□No				
Division	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Fla	ace of Injury - At houlding, etc. (Specify		reet, factory, offic	е		ion (Street an or Town, State		ural Route Number,	
ō	tel or rs aft al Di	Cer		Uh									
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical	Examiner: On the	e basis of examinat	wledge, dea tion and/or it	th occurred at the ovestigation, in m	time, date a y opinion, de	and place, and due to eath occurred at the	the cause(s) time, date and	and manner as diplace, and due	s stated. e to the cause(s)	
	To the within 2 To the I complet	Med	one) 29b. Signature and title of certifie		nanner stated.		29c. Lice	ense number		29d. Da	te signed (Mont	th, Day, Year)	
	N N N		District and the district	700	M	D	-	D4	1104		125		
•	1		30. Name and address of person	who completed c	ause of death (Item	23a) (Type	, Print) \	7			*	-	
	70		Ted House	MD	475	Visi	57	Tow	son M	> 2(204	•	
		ate	31. Date filed (Month, Day, Year,	32	2 Megistrar's Signa	ture	and I						
	Regist	rar	JAN 2 5	2005	4 624 A	s pos							

			1 - For State Registrar	State of Ma	ryland /	Departme <i>Certifica</i>			nd Mental Hy	giene Reg. No. 005	01641
	Physic /Medi	al	Decedent's Name (First, Middle, La Doris E. Degen A. Facility Name (If not institution, given			4b. Ci	v. Town. o	r Location of	2. Date of Dea Month January	Day Year	3. Time of Death 5:15 P. M
	Examir Funeral Director	ier	Country Companio	n Assisted	(In yrs. last b	Та	neyto	W∏ If Under 24		Carroll (Carroll (Ca	thplace (State or Foreign ountry) ryland
	sa-f show	Director	Usual Residence of Decedent 10a. State Maryland Baltimo	ce	10c City, Too Baltim					10 - Citizan et Mhas C	10d. Inside City Limits 1 Tyes 2 No
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-f show other treumatic event, tre Medical Examiner must be notified at	by Funeral	10e. Street and Number 5936 Prince Geor 11. Marital Status 1□ Never Married 2□ Married 3 ☑ Widowed 4□ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was De	Zip Code 21207 cedent of Hoecify Cuba 2⊠ No	lispanic Origii an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		encan Indian,
21215-0036	d within 72 ho giene. ar then "netur i tre Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		+)	a. Decedent's U (Give kind of life. DO NOT Switch	work done use retired	during most of 0) Opera	tor	16b. Kind of Business Realtor	/Industry
Maryland	should be filed and Mental Hygis marked other	To Be C	17. Father's Name (First, Middle, Last Earl 19a. Informant's Name/Relationship	Price	19	h Mailing Addr	ass (Street	An	<u> </u>	Maiden Sumame) Mueller er, City or Town, State,	Zip Code)
	Pages 1 and 2 sho nent of Health and sut: If item 27 Is m ury or other treum		Jo Ann E. Kerna: 20a. Method of Disposition 1□Burial 2☑Cremation 3 [n (Daughte	20h Place	_	akene	y Road	Date Date	re, MD 2122 20c. Location - City or	8 Town, State
Baltimore,	permit. Pages Department of Importent: If is any injury or once.		' 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lices)		6 10	22. Name	and Addre	ss of Facility	Loudon Par	Baltimore, k Funeral hore, MD 21	Home
	Physician /Medical		23a. Part: Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	10.				ardiac or respiratory at Lent Leveus e		Approximate Interval Between Onset and Death
760,	te be executed many sysician and surial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. After Due to (or as c. Due to (or as d.	a consequence	a of): `	100 C	ular	disees <		asyens.
O. Box 68	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 교 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal	th 3□Ectopio 5□Other		y		23d. Date of de Month	livery Day Year
Records, P.	e faw requires has been sign je 2 should be	Completed by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlyin	g cause giv	en in Part I.	1 24a. Was	an 24b. Were a prior to death?	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 2 No
sion of Vital	ding Physicien: After this certifica	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending investigation		y Year) 28b	. Time of Injury M	28c. Injur Wor	er: 4 🗆 Nurs	of Death (Check only of sing Home 5 \sum Residue) Residue 28d. Describe I	dence 6 T Other (Spe	Pocify) Assisted, Living
Division	i Dife	al Certification;	3 Suicide 6 Could not determined 29a. Certifier 1 Certifying P	building, etc	c. (Specify) of my knowled	ge, death occur	ed at the ti	me, date and	City or Tou	Street and Number or R wn, State) cause(s) and manner a date and place, and du	s stated.
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	(Check only 2 Medical Example of certifier	and manner sta			29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	X		30. Name and address of person who was a second of the sec	endoza		10/5/0	Cf	Bole	Rd	Westmin	SomPaus
	St Regist	ate rar	JAN 2 5 200	Bereit	ar's Signature	partie					

05-00292 B.K.S ANDRE DYER

RE I	YER	-	For State Registrar	State of	of Marylan	-	artment of Hertificate of E			giene Neg. No. 00	5 (1642	
			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ıth	(021	3. Time of Death	
	Physici /Medio		Andre Dyer						JAN.	12, 2005		0152 A M	
4	Examin	er	4a. Facility Name (If not institution UNIVERSITY H	OSPITAL	mber)		BALTIM	ORE CITY		4c. County of	Death A		
	Funeral Director		5. Social Security Number 210-48-3160	6. Sex 1 M 2 ☐ F	7. Age (<i>In yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10/21/	, Year)	Birthplac Country, Phila		
			Usual Residence of Decedent						10/21/	07			
	anylan show	_	10a. State 10b. County			ty, Town or Lo					10d.	Inside City Limits 1 ☐ Yes 2 ☐ No	
	the Ma	Director	PA Phi 10e. Street and Number	<u>ladelphia</u>	Pl	hilade.	Lphia 10f. Zip Code			10g. Citizen of Wh	at Country	Λ	
337 North Horton Street							19139			USA			
	death ms 2;	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	.s. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race -	American White, etc		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or items 23s or 28a-f show any injury or other traumatic event, if a Nadical Examment initial be inclifted at ance.	by Fu	1 Never Married 2 Marri 3 Widowed 4 Divorced	ried 1 ☐ Yes If Yes, Gi	2 XNo ive		1 ☐ Yes 2 X No	Specify:	riicari, etc.,		Black		
Maryland 21215-0036	2 hou	ted	15. Deceden	t's Education st grade completed)		16a. Dece	dent's Usual Occupa kind of work done di	tion	ina	16b. Kind of Busi	ness/Indus	try	
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (life.	DO NOT use retired)			- 47.14			
121	iled w tygier ther th	So	17. Father's Name (First, Middle,	lastl '	G.	Co	<u>nstruction</u>	n Worker 18. Mother's Name	(First, Middle.	Buildi Maiden Sumame)			
anc	d be fi	o Be	Arnold						Royster				
ary	2 should and Men Is marke aumatic	은	19a. Informant's Name/Relations			19b. Maili	ng Address (Street a			r, City or Town, St	ate, Zip Co	ode)	
	and 2 ealth a n 27 ls			Dyer/ Bro			Locust S						
3altimore,	of He of He If item		20a. Method of Disposition 1 → Burial 2 ☐ Cremation	3 ☐Removal from		Place of Dispo cemetery, crei	sition (Name of natory or other place)	Date	20c. Location - Ci	•		
tim	Page tment tent: h		`4 ☐ Donation 5 ☐ Other (S	(pecify)	Fe	rnwood	Cemetery	1/2	0/05	Fernwood	Pen	na.	
Ba	permit. Departr Importe any inji		21. Signature Funeral Service	L'EN	faite	d	Name and Address	OLI VER	OMORTIE 5T L	Ballos !	nd.	31213	
			23a. Part1. Enter the disease of shock, or heart failure. Vist	complications that only one cause on	caused the deat each line.	th. Do not ent	er the mode of dying	, such as cardiac o	or respiratory are	rest,	Ar In O	oproximate terval Between nset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a M	Witip	11 E	unsho	+ Wor	inds				
	/Medical Examiner			Due to	(or as a con	uence of):							
		Jer	Sequentially list conditions, to the cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	or as a consec	uence of:							
11	ecuted and I-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	cate be executed obysician and the burial-transit		resulting in death) Last	Due to	(or as a conseq	(uence or):							
687	ficate physis	edicai		d.									
	death certific ettending pl	an/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnancy			23d. Date of		ıy Year	
Vital Records, P.O. Box	the the	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of c	death 5	Other (specify)			Work	1 50	iy roat	
۵,	s that the	by Pf	Part II. Other significant condition	ons contributing to c	death but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib			
ord	w requires that been signed E should be deta	ted !							1 □ Y	es 2/2/No 3	Probabl	y 4 Dunknown	
ecc	e law r has be ge 2 sh	Completed							24a. Was a autop	sy pric	ere autopsy or to compl ath?	findings available letion of cause of	
al H	ilclan: The certificate I rector, pag								10 Yes	2 □ No 1 □	Yes 20	□ No	
Vit	siclar certif	o Be	25. Was case referred to medica examiner? 1 X Yes 2 No	Hospital:	Inpatient 2X	ER/Outpatier	ot 30 DOA Othe	26. Place of Death		ne) ence 6 □Other	(Specify)		
of	g Phys er this ieral di	\vdash	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o				ow injury occurred			
ion	ittending I death. ctor: After y the funer	atio	1 Natural 5 Pendir investi	gation 1 1:	205	1:21	AM 104	res 2 🕅 No	Suh	rect sh	ot		
Division of	or Attendate death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	.: 280. Flac	e of Injury - At h ling, etc. (Specia	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State) (30)	DIZIK		
Ω	pital o	Ce	29a. Certifier 1 ☐ Certifyir	ng Physicien: To th	e hest of my kno	JV26	occurred at the tim	e date and place	and due to the o	e V ST	er as state	timere MD	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) Medical	Examiner: On the b	pasis of examina nner stated.	ation and/or in	vestigation, in my op	ninion, death occurr	ed at the time, o	date and place, and	d due to th	e cause(s)	
	To th withir To th	Ň	29b. Signature and title of certifie	1 1	nend)	29c. License	number C.M.E	2	JAN. 12			
	7		30. Name and address of person	who completed cau		n 23a) (Туре, PENN	STREET, BA	ALTIMORE,	MARYLAN	D 21201			
	Sta	te	31. Date filed (Month, Day, Year)	32.	gistrar's Signa		0720						
	Regist	ar	JAN Z	5 2005	low.	15 B	asus.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Physician anaher 8:45 2005 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner GENESIS ELDERCARE - CROMWELL TOWSON BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours 1 □ M 2 🖫 F Yrs 89 Director 9/9/1915 MARYLAND 216-01-9552 Usuel Residence of Deceden filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 1 Yes 2 No Director MD BALTIMORE TOWSON items 23a or 28a-f 10f. Zip Code 10e Street end Number 10g Citizen of What Country? 10 ECOWAY COURT #3-D 21286 Funeral USA 14. Race - American Indian, or items 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 反 No Specify: Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12TH GRADE HOMEMAKER Pages 1 and 2 should be filed nant of Health end Mantel Hygint: If Item 27 Is marked other other traumatic event, 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JACOB PUHL ELIZABETH SCHAUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY DANAHER DAUGHTER 10 ECOWAY COURT #3-D TOWSON, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) METRO CREMATORY, 1/25/05 CATONSVILLE, MD INC. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Pert1. Enter the disease, or complication, that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Betwe Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical neumonia Examiner Due to (or as e consequence of) Be Completed by Physician/Medical Examiner use as the burial-transit or Attending Physician: The law raquiras that the death certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Due to (or as a consequence of) signed by the e Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 🗆 Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 LNo this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred eral Director: After filled in by the funer 1 ONatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. completaly (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) (su 5601 Loch Gin 32. Restrer's Signeture State 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 05 0/644 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 24,2005 ear **Physician** 12:50 a м Iva May Diefenbach /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 7, 1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔽 F Maryland 215-12-3994 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Directo Carroll Westminster Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 721 Glen Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify φ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary State of Marvland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mable Holly Owen Leaverton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Melanie J. Mack / Daughter 721 Glen Drive Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/05 1 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkville, Maryland 21. Signatur Funeral Service Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Cen au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardisonyopathy Due to (or as a consequence of): Priysician ears /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year be detached for 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 (No o the Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₩No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? Certification: Natural Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\vee_{\!\!\!\!\! \gamma}$ Westminster toner Rus ivillow 31. Date filed (Month, Day, Year)

JAN 2 5 32. Reginar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 0336 AM 22 WILLIAM EARL 200.5 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ARKVILLE r 1 Year | If Under 24 Hrs. Hours | Min. BALTIMORE 3205 Woodside If Under 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M M 2 □ F Date of Birth (Month, Day, Year) **Funeral** Months Yrs. 215-25-7080 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo BALTIMORE Director MD Parkvill 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3205 USA Ave 21234 side Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) chucation tudent 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event OREs. Be Williams. illiam 19b. Mailing Address (Street and Number or Rury Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tarkville nother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Evans Funcial Chapel-Belfir 1-24-05 Forest Hill, MD 22. Name and Address of Facility BALTIMORE, MO 21234 21. Signature of Funeral Se vice Licensee EVANS FUNERAL CHAPEL, 8800 HAKFORDED muche 23a. Part 1. Enter the disease, or complications that "sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List, inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Sping BiFidA ot Complications of Due o (or as a consequence of): **Physician** 10 years /Medical Examiner Sequentially list conditions, if any, leading to immediate rains. First Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: Hospital: 1 Yes 2 No 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No investigation Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier WHE MID 1866 JANHARY 22,2005 DEPUT 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 6 Trimble Hill CT. Luthaville, Mary Land PHILIP MILITELLO, MD 31. Date filed (Month, Day, Year) 32. Reistrar's Signature JAN 2 5 2005 Registrar

DHMH 17 Rev 1/2001

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	Physici /Medic		1. Decedent's Name (First, Middle, Last) Margaret Emily Evans	Ja		2, 200 ^y 5 ^{ar}	3. Time of Death 5:30 A. M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo Baltimo	ore		c. County of Death	
	Funeral Director		212-30-7481 1 M 2 DMF 85 Yrs. Months Days	Hours Min. Ma	Date of Birth (Month, Day, Yea By 13, 19	9. Birth Mary	place (State or Foreign 1and
	Maryland f show	ō	Usual Residence of Decedent 10a. State				10d. Inside City Limits
	a with the 13a or 28e-	Il Director	10e. Street and Number 2700 N. Charles Street	21218	10g. C	Citizen of What Cou USA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or iteme 23a or 28e-f show simportent: if item 27 is marked other then "natural; or iteme 23a or 28e-f show simply injury or other traumatic event, it a Madical Examination and once.	by Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 3 Married 3 Married 3 Married 2 Married 3 Married 3 Married 3 Married 4 Divorced 4 Divorced 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 3 Marrie	panic Origin? (Specify Mexican, Puerto Rica Specify:	y Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Wh	
21215-0036	d within 72 ho jiene. r then "naturi it e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired) Seamstress	on ring most of working		Kind of Business/Ir	ndustry
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	1 and 2 shoi Health and N Iem 27 is ma		Shirley Evans Daughter-in-law 19b. Mailing Address (Street and 900 W. 38th Str				
Baltimore,	Pages 1: ment of He ent: If iten ury or oth		20a. Method of Disposition 1 \(\bigsize \) Burial 2 \(\bigsize \) Cremation 3 \(\bigsize \) Removal from State \(\bigsize \) Donation \(\bigsize \) Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery	1/26/20		ckville,	
Balt	permit. Pag Department Importent: I any Injury o		21. Signature of Eureral Service Licensee Burgee-Hensel 3631 Falls 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	<u>Road, Balt</u>	timore, M	ome, Inc. Maryland	21211
8760,	The law requires that the death certificate be executed at the law requires that has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	llcal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypothemical death of the provided of the provi	me Diseau tun			Interval Between Onset and Death
.O. Box 6	that the death certifice led by the attending ph detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 Unknown 5 Other (specify) 1 The past 12 The past 12 The past 13 The past 14 The past 14 The past 15 The			23d. Date of deliv Month	ery Day Year
D	uires that t signed by lid be detai	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Corelan vanual Brei dend	in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
al Records,	: The law requir cate has been si ; page 2 should	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
of Vital	Physician: Th this certificate ral director, pag	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	6. Place of Death (C	5 Residence		(y)
Division	Attending or death. ector: After by the fune	Certification;	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide	s 2 No	Location (Street a City or Town, Sta	and Number or Rura	al Route Number,
۵	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, and manner stated.	date and place, and ion, death occurred a	due to the cause(at the time, date ar	s) and manner as s nd place, and due to	tated. o the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier D31		29d. D	ate signed (Month,	Day, Year)
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOALS A. HASHMI, 821 N. Switon 31. Date filed (Month, Day, Year) JAN 2 5 2005 JAN 2 5 2005	8r Smte	308	Bultin	noe MP 2120
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 5 2005 32. Registrar's Signature				

FIELDS, LAWRENCE 05-00355 LEW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	ryland / Depa <i>Cei</i>	artment of H rtificate of I			iege) 05	01647	
	Physicia		Decedent's Name (First, Middle, La		ce Fields,	Jr.		2. Date of Deat Month January	Day Year		
	/Medic Examin		4a. Facility Name (If not institution, gir U of MD Shock Tra	ve street and number)			Location of Death	, , , , , , , , , , , , , , , , , , , ,	4c. County of De		
*.	Funeral Director		215-15-6052	Sex 7. Age 1 1 □ M 2 □ F	(In yrs. last birthday) 17 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 1,		irthplace (State or Foreign Country) Maryland	
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ector	Total years	N/A	10c. City, Town or Lo		altimore	11	On Citizen of What	10d. Inside City Limits 1 △ Yes 2 □ No itizen of What Country?	
	23a or 2	Funeral Director	10e. Street and Number 2513 Ridgley Street				21230		U.	S.A.	
920	urs after dea al', or items Examiner m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2□x No	ispanic Origin? (Spo an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importament of Health and Mental Hygiene. Importament if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinational Department on the Department of the Medical Examination of the Me	Completed	15. Decedent's E (Specify only highest gi		(Give	DO NOT use retired	during most of work	ing	16b. Kind of Busines Publi	s/Industry c school	
and 2	2 should be filed withi and Mental Hygiene. Is marked other than aumatic event, the M	Be	10 17. Father's Name (First, Middle, Las	e Fields Sr			18. Mother's Name		naiden Sumame) queline Hill		
Maryland	d 2 should Ih and Men 7 Is marke traumatic	ပ္	19a. Informant's Name/Relationship Lawrence Fields, Sr Fa	(Type, Print)			and Number or Run		City or Town, State	, Zip Code)	
Baltimore, I	Pages 1 and 2 nent of Health ant: If item 27 I ary or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec	Removal from State	20b. Place of Dispo		ee)		20c. Location - City of	or Town, State	
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service tice	insee	22	. Name and Addres	ss of Facility rothers Funer utaw Place B	ral Home P.A	\ \.21217		
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	shot wo	er the mode of dyin	g, such as cardiac	or respiratory arre	est.	Approximate Interval Between Onset and Death	
	/Medical Examiner		1	b	consequence of):						
	and I-transit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
8760,	icate be executed physician and s the burial-transit	dical E	(d						/	
Box 6	The law requires that the death certific ste has been signed by the attending pl page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year	
ds, P.O.	uires that I signed by Ild be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown	
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Vital		To Be (25. Was case referred to medical examiner? 1 ∑Yes 2 □ No	Hospital: 1 Inpatient	t 2 🔽 ER/Outpatier	at 3 DOA Oth	26. Place of Deatler: 4 ☐ Nursing Ho		nce 6 Other (Sp	necify)	
Division of	Jing After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending investigation	111710		Worl	k? Yes 2 No	28d. Describe ho	bject si	het	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not determined		y - At home, farm, str (Specify)			28f. Location (Str City or Town	Balt Muve Balt Muve	Herranst	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical		hysician: To the best of miner: On the basis of e and manner state	xamination and/or in						
	To th within To th comp	M	29b. Signature and title of certifier	100		29c. Licens			anuary 15		
•	1/1/		30. Name and address of person who	completed cause of deal AA) Nu A				CIMORE, N		21201	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 5 2	32. Begistrar				, , ,			

			1 - For State Registrar	State of Maryla		artment of H			2005	01648
	Physic /Medi		Decedent's Name (First, Middle, Lase Mary	Fallon				2. Date of Death Month January	Day 200!	3. Time of Death 5:10 A M
	Exami		4a. Facility Name (If not institution, give	ing Home			ville	th	4c. County of D	
	Funeral Director		5. Social Security Number 6. Se 352-09-7605	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		(ear) 1919	Birthplace (State or Foreign Country) Illinois
	72 hours after death with the Maryland neturel', or Items 23e or 28a-f ehow disel Examinar must be notified at	ector	10a. State 10b. County Maryland Carrol 10e. Street and Number		Sykes	cation SVIIIe 10f. Zip Code			0	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	be filed within 72 hours after death with the Marylan nat Hygiene. Identify then "neturel", or Items 23e or 28a-f ehow od other than "neturel", or Items 23e or 28a-f ehow event, I'm Wedfeal Examinat must be notified at	Funeral Director	710 Obrecht Road	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	2178 Was Decedent of His Yes, specify Cubar			J. Citizen of What US 14. Race - A Black, W	Merican Indian,
21215-0036	72 hours aft neturel', or l	by	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad	1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	16a. Deced	I ☐ Yes 2 ☒ No	Specify:	16	Specify:	White
d 2121	filed within Hygiene. ther then "	e Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+) n/a	life. L	kind of work done do DO NOT use retired) etary		me (First, Middle, Ma.	Medica	al
Maryland	2 should be and Mental Is marked o	To Be	Stephen Balo		19b. Mailin		Mary			ə, Zip Code)
	as 1 and of Health litem 27		Mr. Thomas Fallon 20a. Method of Disposition 1 Dispusal 2 Cremation 3 DF		Place of Dispos	Boston S sition (Name of natory or other place		Baltimore Date 200	, Maryla c. Location - City	and 21224 or Town, State
Baltimore,	permit. Page Department of Importent: If eny injury of once.		* 4 Donation 5 □ Glher (Specify) 21. Signature of Funeral Service Lights		22	ley Mem. Gdi Name and Address CK Towson Fi	s of Facility	5/2005 Ti me, Inc. 1050		Maryland 21204 d Towson Md
	Fnysician /Medical	2. IV	23a. Part1. Entel the disease, discomplishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the dealer cause on each line. Due to (or as a consec	th. Do not ente	er the mode of dying	, such as cardia	c or respiratory arrest,	,	Approximate Interval Between Opset and Death
90,	Examine physician and physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer Indentyin Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):					
.O. Box 68760,	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn: 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of c	lelivery Day Year
rds, P	taw requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not res	sulting in the un	derlying cause giver	n in Part I.	23e. Did tobaca		to the cause of death? Probably 4 Unknown
	The ate h page	Completed						24a. Was an autopsy performed	l? prior to	autopsy findings available completion of cause of ss 2 \square No
Division of Vital	Phyer this	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other 28c. Injury a Work? M 1 Ye	4 Ursing H	th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Street	njury occurred	.,
٥	Hospital 4 hours Funerel iely filled	edical Ceri	29a. Certifier 12 Certifying Phys	building, etc. (Specifications: To the best of my known and manner stated	owledge death	occurred at the time	, date and place	City or Town, St	· · · · · · · · · · · · · · · · · · ·	as stated.
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	4/1	MO	29c. License			Date signed (Mor	
	3		30. Name and address of person who co Wilbur Kuo, M.D. 31. Date filed (Month, Day, Year)	295 Stoner A	venue	Suite 307	7 Westm	inster, Ma	aryland	
	Sta Registr		IAN 9 5 2	32. Registrar's Signa	uure !/a	/				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 22, 2005 Thomas B. Foster, Jr. 11:20 P M /Medical 4a. Facility Name (If not institution, give street and number)
2950 Rose Crown Circle 4b. City, Town, or Location of Death Pasadena Examiner 4c. County of Death Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | April 22,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1√XM 2□F 214-14-2506 Yrs Director 85 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Maryland Anne Arundel Pasadena Director 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2950 Rose Crown Circle 21122 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 12(25)Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or iten any findry or other traumatic event, Ita Marical Exacting 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3℃Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore Gas and Electric Elementary/Secondary (0-12) College (1-4or 5+) Underground Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas B. Foster, Sr. Mabel Sharp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce Hildebrand Daughter 2950 Rose Crown Circle Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/2005 Glen Burnie, Maryland `4 ☐ Donation, 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Year 4☐Pregnant at time of death Month Day 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 2 No certificate l Division of Vital 1 ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home Residence 6 Other (Specify) 은 1 ☐ Yes 2√ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Jean 28b. Time of 28c. Injury at Work? Certification: After 28d. escribe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) within 2 To the I complet 29b. Signature and title of certifier 29c. License number 30. Name and address of person when completed cause of * ath (Item 23a) (Type, Print) Pasadena Md 211 VOM 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

		State of Maryland / Departr 1 - State Registrar Certific	ment of Health and Nicate of Death	Mental Hygier	L 0 0 0	01650
		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Yeer	3. Time of Death
Physicia /Medic		William Dorus Flora		Jan. 21,	2005	9:20 P M
Examine		4a. Facility Name (If not institution, give street and number) 4b	. City, Town, or Location of Death		4c. County of Deatl	
		Charlotte Hall Veterans Home	Charlotte Hal		St. Mary	
Funeral		100 M 2 F	onths Days Hours Min.	(Month, Day, Ye	ar) Co	nplace (State or Foreign untry) irginia
Director		236-10-9915 88 Yrs. Usual Residence of Decedent		Aug. 11,	1310	ii giii a
Maryland -f show fied at		10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
Ba-f s	Director		Parkville			1 ☐ Yes 2X☐ No
ith with the Marylan 23e or 28e-f show ust be notified at	Dire		Of. Zip Code	10g.	Citizen of What Co	untry?
death v	eral	2720 Superior Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21234 Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	rican Indian.
after dea or items	Funeral	1 Never Married 2 Married 1 √ Yes 2 No	Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	a, etc.
urs a	þ	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WW I I	Yes 2 X No Specify:		Specify: Wr	nite
"natural",	etec	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of work	ting 16b.	. Kind of Business/l	industry
within jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	alesman	.1	ack's Tir	e Service
年工芸芸	မ င်	17. Father's Name (First, Middle, Last)		e (First, Middle, Maio		C 3C1 11CC
	To B	W. P. Flora	C1	iara Monto	omerv	
2 should be and Mental is marked craumatic sv			ddress (Street and Number or Run	al Route Number, Cit	ly or Town, State, Z	ip Code)
and 2 saith a n 27 is			ickling Brook Ro			
of He		20a. Method of Disposition 1 🗶 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cremato.	ry or other place)		. Location - City or	
Pag tment tant: jury o		`4 □Donation 5 □Other (Specify) Dulaney Val	ley Mem. Grd. 1/			
permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked any injury or other traumatic stones.			me and Address of Facility Ruc 50 York Road To			
		23a Part1. Enter the disease, or coruc ications that cause the death. Do not enter th			J runa 222	Approximate
Discolution		shock, or heart failure. List only one cause on each line.	,		0 -	Interval Between Onset and Death
Physician - /Medical		Immediate Cause (Final disease or condition resulting in death) a. Advanced A12 Due to (or as a consequence of):	-nermer s	Disea	se	years
Examiner		Osteoporosis				years
ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				/
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				weeks
be executed sician and burial-transit	al E	d. Peripheral Va	scular dis	PASE		years weeks months.
physi s the b	dical	d. 1011pherea va	The same of the sa	, casc		Wichtus
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant			23d. Date of deli-	very
death e atte	lcia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Oth	opic pregnancy ner (specify)		Month	Day Year
at the de by the a	hys	9 ☐ Unknown		T		
		Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobaco		the cause of death?
w require been sig should b	eted	SINO-HIVIAL HOUSE AGS FAINE	ALOYL			
e law has b	Completed by	Venous Insufficiency	•	24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
	ို့ ရင်	25. Was case referred to medical	26 Place of Deat	performed 1 Yes 2	No 1	2 No
Physician: this certific ral director,	o B	examiner? Hospital:	Other	ome 5 Residence	6 □Other (Spec	rify)
g Phys ier this ieral dir	L:U	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how in		
endin sath. or: Af he tui	atlo	2 Accident investigation	VI 1 ☐ Yes 2 ☐ No			
or Atter de lirecte n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St		ral Route Number,
Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occ	purrod at the time, date and place	and due to the source	(c) and manner as	etalod
To the Hospital or Attending R within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigned and manner stated.				
To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	· 29d. l	Date signed (Month	, Day, Year)
		Varul Samons	14509	2 1	124/2	005
611		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		055		- 1 . 1
9.		PARUL S. JANI MD. 110 Hospit	al Rd. Suite	205, 1	rince F	redvick, AND 20678
Star Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	seel !		MARYL	MN D 20678

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of	Marylar	nd / Depa		t of H	ealth a	and M	fental Hyg		005	01651
	- · · ·		1. Decedent's Name (First, Middle	, Last)				-			2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		David			Gof	f				January		2005	9:04 AM M
	Examir		4a. Facility Name (If not institution	give street and numb	er)		_	Town, or	Location	of Death		4c. Co	unty of Dea	
			20535 Mockingbi	rd Lane			Nan	tico	ke				Wicon	nico
	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Bi	rthplace (State or Foreign ountry)
	Director		235-62-1249	121M 2UF	61	Yrs.		,-			June 24,	1943		
	pur 🔏		Usual Residence of Decedent 10a, State 10b, County		10c Ci	ity, Town or Lo	cation							10d. Inside City Limits
	sho sho	ž					oution							1 Yes 2 No
	Ne h	Director	Maryland Wicom 10e. Street and Number	100	Nan	ticoke	101 7:	0 1						
	with	급					10f. Zip	Code				log. Citizer	of What C	ountry?
	sath	erai	20535 Mockingbi	rd Lane	nt Ever in I	10 10 1		840	anania Or	ining (Cn	anii. Van as Na		ISA _	adaan ladian
	ter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Force	s?	7.3.	f Yes, spec	offy Cuba	n, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, Wh	erican Indian, ite, etc.
38	urs af	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	2 ½ No	Specify:			Sp	ecify:	L 2 2
ĕ	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinar must be rediffed at	be	15. Decedent	's Education		16a. Dece	dent's Usua	i Occupa	ation			16b. Kind	WI of Business	nite s/Industry
75	n 7.	pie	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	or F : \	(Give	kind of wor DO NOT us	rk done d se retired,	luring mos)	it of work	ing			•
21215-0036	filed within Hygiene. ther than " ont, the Mer	Completed	12	College (1-4	51 5+j	Infor	matio	n An	alysi	t		Godo	lard S	Space Center
	e file of he othe vent,	a	17. Father's Name (First, Middle, I	Last)					18. Mothe	er's Name	e (First, Middle,	Maiden Su	mame)	
<u>a</u>	Mentat Mentat arked o	To B	Annis	Scott		Goff			Ar	iel	I	Bragg	J —	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show titem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations	nip (Type, Print)							al Route Number			Zip Code)
	1 and 2 Health tem 27 I		Teresa L Klug	daughte	r	2105	5 Nan	tico	ke R	oad I	Bivalve	MD 21	814	
or e	of Hea		20a. Method of Disposition	2 [] B		Place of Dispo	natory or ot	ther place	θ)					Town, State
Ē	Pages nent of I int: If its iry or o		1 🖾 Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp		Ce	dar Hil	1 Cen	neter	r'y ¦1	/26/	05 (alen	Burni	e MD
Baltimore,	permit. Pages Department of Important: If it eny injury or once.		21. Signature of Funeral Savio	icensed			. Name and				tallings Pasadena			Home P.A.
			23a. Part 1. Enter the disease, or	complications that cay	sed the deal								. 1 1 2 2	Approximate
, E	Dharistan		shock, or heart failure. List in Immediate Cause (Final	only one dauge on was	h line.	1	1.							Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consec	LVYY W	7 LOU	nu	1					2 mg
	Examiner			1 200 to (0)	40 4 0011000	1401100 017.)							
Ш		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	quance of).							-	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	exec in an rial-tr	Еха	resulting in death) Last	C. Due to (or	as a consec	quence of):								
8760,	The law requires that the death certificate be executed attempted has been signed by the attending physician and page 2 should be detached for use as the burial-transit	licai		d										
9	tifical g ph	edi		1										
Box	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Tatania au					23d	. Date of de	livery
	deatl e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnan	t at time of c		Ectopic pre Other (spe						Month	Day Year
P.0	if the by th tache	hys	9 ☐ Unknown	9□ Unknow	1								_	
	res that the de signed by the a I be detached f	ру Р	Part II. Other significant condition	ns contributing to deat	h but not res	sulting in the u	nderlying ca	ause give	n in Part I	-	23e. Did tol	pacco use	contribute t	o the cause of death?
Ď	w require been sig should b	ed					_				1 □ Ye	es 2□N	0 3□P	robably 4 Unknown
Records,	aw requ is been 2 shoul	Completed									24a. Was a		4b. Were a	utopsy findings available
Ä	The lay	E									autops perform	ned/ 2 M No	death?	completion of cause of
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical		<u></u>				26. Place	of Death	Check only on			20110
>	S S F	To B	examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatien	t 3 DO	A Othe	r: 4 □ Nu	irsing Ho	me 5 Reside	ence 6	Other (Spe	ecify)
J Of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time of Injury	28	8c. Injury Work	at		28d. Describe ho			
<u>Ö</u>	ttendir. death. ctor: Af / the fu	atic	2 ☐ Accident investig	ation	,	,,	М		∕es 2□	No				
Division	r Attender death rector:	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	Injury - At h etc. (Special	ome, farm, str	eet, factory,	, office			28f. Location (St City or Town	reet and N n. State)	umber or R	ural Route Number,
ā	tel or	Cer		1										
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) Check only one)	g Physician: To the be Examiner: On the basis and manner	s of examina	owledge, death ation and/or inv	occurred a restigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the ca ed at the time, d	ause(s) and ate and pla	manner a	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c.	. License	number		2	9d. Date si	gned (Mon	th, Day, Year)
) .	F \$ F 0	7/	1 XCAA	MA				1	1050	1		1	110	
	216		30. Name and address of person	who completed cause of	of death (Iter	n 23a) (Tyne	Print)	U	430	/				
1	O(°		TACOMW N	GRASSO		5 E	(n	topi	122	5+	SAU	SMAM	200	mo
	Sta	ite	31. Date filed (Month Day, Year)				010	1000		-	-1) 01	- 15 V10	7	r F F Tape
	Registr		10N 2 5	2005	les	ature	make.	9						
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DHMH 17 Rev 1/2001

Registrar

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			1 _ For Stete	State of Marylar	•	ent of Health and		Z U U Ə -	01653
_			Registrar		Certific	ate of Death	Reg.	. No.	
	Physicia	an	1. Decedent's Name (First, Middle, La				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		SAM LEON	<u> </u>			JANUARY	21 200	
7	Examin	er	4a. Facility Name (If not institution, gir			city, Town, or Location of Dea		4c. County of Dea	ith ∕1
						3ALT IMOR			4
п	Funeral		5. Social Security Number 6.3	5ex 7. Age (In yrs.	Yrs. Mont			ear) -// A9	thplace (State or Foreign ountry)
	Director	4	Usual Residence of Decedent	1 30			INDV. 26,1	1954 IVI	aryland
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	Maŋ -f sh	ţ	Maryland N/A	1	Baltime	200			1 XYes 2 No
	r 28a	Directo	10e. Street and Number			Zip Code	10g	. Citizen of What C	ountry?
	3a o	0	1603 1001	st St		21226		11 <	A
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was Do	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Am	
ဖွ	after or ite	Ī	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		specify Cuban, Mexican, Pue s 2 X No Specify:	to Hican, etc.)	Black, Whi	te, etc.
5-0036	72 hours after death with the Maryland natural, or items 23a or 28a-f show Item Examulat Let collified at	Completed by	3 ☐ Widowed 4 🕱 Divorced	Year or Dates:	1316	5 2)23240 Specify.		Specify: B	lack
5-(72 h	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's l	Jsual Occupation work done during most of wo Tuse retired)	orking 16	b. Kind of Business	/Industry
121	within iene. than *	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	1		1000	1 -
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Ē	hould to Ment marked marked	۲	19a. Informant's Name/Relationship	Type Print Sister-In-	and hop Mailing Add	ross (Street and Number or 9	VII E D	YIA	Zio Codo)
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ē,	1 and Health tem 27 other tr		20a. Method of Disposition	206.1	Place of Disposition	Name of	Date 20	c. Location - City or	Town, State
<u>0</u>	ages int of t: if if		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	_Removal from State 🔥	cemetery, crematory	or other place)	7/2005 G		M 1
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examment invalue incitified at ances.		21. Signature of Funeral ServicerLice		eaal 22. Name				irnie, Mai
Ba	Dep Impe		Norohl	J. KILL	1/ Jose	and A dres of Facility h North Au	Funeral t	tome	11.
	100		23a. P. 11. Enter the disease, or consider, or heart fairly e. List only	plications that cause the deal	th. Do not enter the	mode of dying, such as cardia	c or respiratory arrest	141a. 212	Approximate
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7	/Medical		disease or condition resulting in death)	a. Due to (or as a consec		CARCINOL	1 <i>H</i>		One year
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Records,	Se 100	Completed by	Tarini onio oigimoani oini	on the day of the form	saling in the underlying	ig cause given in Part i.			robably 4 Unknown
or.	w require been signal	etec						2010 00	
3ec	e la has	npi					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
al F								d? death? No 1 ☐ Yes	2 No
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of	Phys this ral di	٠ <u>۲</u>	1 Yes 22 No	28a. Date of Injury	ER/Outpatient 3 28b. Time of	DOA 4 Nursing	Home 5 Residence		ecify)
ם	ding Phy h. After thi funeral o	lon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred	
Sic	Attending r death. ector: After by the fune	ica	3 Suicide 6 Could not	De Diana of laine. As h			28f. Location (Stree	at and Number or P	ural Poute Number
Division	l or A after Dire	Certification;	4 Homicide determined	building, etc. (Speci	fy)	ory, omea	City or Town, S	State)	urar rioute reuniber,
	spita lours neral	ac	29a. Certifier 1 Certifying P	hysiclen: To the best of my kn	owledge, death occur	red at the time, date and place	e, and due to the caus	se(s) and manner a	s stated.
	e Ho 124 h e Fu	edical	(Check only 2 Medicel Exa	miner: On the basis of examina and manner stated.	ation and/or investiga	tion, in my opinion, death occ	urred at the time, date	and place, and du	e to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier Moulhami. H	adala (HOUSE	OFFICER)	29c. License number		Date signed (Mon	th, Day, Year)
			Marsham. Fl	Liver Circust		RES 000	JA	NUARY, &	21, 2005
	1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	11001011500			21225
	2		MADHAVI. MADA			HANOUER ST	, 5 A	LITTORE	スノスムコ
:-	Sta Registi		31. Date filed Month Day, Year)	32. Registrar's Sign	ature				

Fred 05 - 0		۱.	German III Please T	ype or Print in Bla	ck Indelib	le Ink. Ensu	ure All	Copies .	Are Legible.	
AKG			1- For Unpend Item :	State of Maryland / 23a, 27, 28a f per	Department Certifica	of Bealth ate of Death	and Me		iene 005	01654
	Physici	an	Decedent's Name (First, Middle, Last)	1 0	,			. Date of Deat Month	h Day Year	3. Time of Death
	/Media	cal	treclerick	H. Germa		<u> </u>		anuary	21, 2005	2:17 P M
7	Examir	ner	40. Facility Name (If not institution, give s 404 South Philadel			ty, Town, or Location rdeen	of Death		4c. County of Dea	
7497	Funeral Director		5. Social Security Number 6. Sex 213-92-8330 Usual Residence of Decedent	M 2□F 7. Age (In yrs. last t	Yrs. If Und Month	der 1 Year If Under is Days Hours	Min.	Date of Birth (Month, Day, 5-30	Year) 9. Bi	rthplace (State or Foreign country) ARYLAND
	filed within 72 hours atter death with the Maryland Hygiene. thar then "natural", or tiems 23a or 28a-f show that the Medical Examinar must be notified at	_	10a. State 10b. County		wn or Location			·		10d. Inside City Limits
	28a-f	ecto	10e. Street and Number	10RE		KUILLE				1 Yes 2 No
	th with 23a or	Funeral Director	0,228 16 from	View Da	107.	Zip Code	/	'	Og. Citizen of What C	
	ms 22	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dec		igin? (Speci	v Yes or No-	14. Race - Am	
9	or iter	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		pedent of Hispanic Or pecify Cuban, Mexical		ean, etc.)	Black, Wh	
5-0036	ours a	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:	:		Specify:	shife
5-6	"natu	etec	15. Decedent's Educ (Specify only highest grade	cation 16 completed)	a. Decedent's U: (Give kind of	work done during mos	st of working		16b. Kind of Business	:/Industry
2121	withir iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	IIIO DO NOT	use retired)	oton		Pales: 1	tome Taxa
	be filed tal Hygid of other event, III	Be C	17. Father's Name (First, Middle, Last)		e au	18. Moth	er's Name (/	First, Middle, N	Maiden Surname)	TIME LINE
Maryland		ToE	Frederick A. (serman JA)		nna	J. "	Small	
lan	and and is m		19a. Informant's Name/Relationship (Type	De, Print)	b. Mailing Addre	ess (Street and Number	er or Rural F	Route Number	City or Town, State,	Zip Code)
	s 1 and 3 if Health item 27 other tra		Hederick H. Gen	Man, JR. 9	328 H	artord V	iew	DR. K	rkville 1	11 D21234
آور	S 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	of Disposition (Nery, crematory)	r other place)	Date		20c. Location - City of	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	EVAUS	FUNERA	CHAPEL -	1-ZZ	5-05	Forest H	FIL MO
Ba	permit. Departr Importu any inji		Kim her Orall	2.10	22. Name	and Address of Facili	BITCI	MOKE	i, me) 21	204.
	10100		23a. Part1. Enter the disease, or simple	ation that cau ed the deth. Do	not enter the m	ode of dying, such as	cardiac or re	espiratory arre	SOOHARE	Approximate
	Physician		Immediate Cause (Final	Alcohol Intox						Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	9 of):					
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68760,		icai E								
89)	ertifica ing ph e as II	Med	IF FEMALE:	-						
P.O. Box	Attending Physician: The law requires that the death certificate be ex refaith. sctor: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buriary.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic 5 Other (23d. Date of de Month	livery Day Year
	es that thighed by be detact	by Ph	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying	cause given in Part I		23e. Did tob	acco use contribute to	o the cause of death?
of Vital Records,	v requires been sign should be							1 ☐ Ye	s 2 √No 3 □ P	robably 4 Unknown
9	e law re has be je 2 sho	Completed						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
<u> </u>	The late has page	Con						perform	ed? death?	s 2 No
/ita	i cian : Th certificate rector, pag	Be	25. Was case referred to medical examiner?			_	of Death (C	check only one)	
of	ding Physician: h. After this certific funeral director,	2	1XXVes 2 No Proceedings No. 1XXVes 2 No. Proceedings No. Proc	ospital:					nce 6 NOther (Spe	
uo	ding h h. After funer	tion	1 Natural 5 Pending	Found h. Day Year) For	Time of	28c. Injury at Work?		. Describe ho	w injury occurred	unk
Division	Attendi death. ctor: A	flca	3 ☐ Suicide 6X Could not be	1-21-05 2:0		1 □ Yes 2 🛣		Location (Str	eet and Number or R	ural Route Number
Div	al or / s after il Dira	Certification;	4 Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify) Found at home	, 011001, 1201	.,,	R1	City or Town,	State) 404 S. erdeen. Md	Philadelphi
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	dical ((Check only A Medical Examin	ician: To the best of my knowledger: On the basis of examination a	ge, death occurre	d at the time, date an	d place, and	due to the ca	iso(s) and manner a	s stated
	thin 2 tha mplet	Med	29b. Signature and title of certifier	and manner stated.		9c. License number			d. Date signed (Mont	
	6 1 € 1		101150 h	(X6,00 Aug		O.C.M.E.				•
			30. Name and address of person who con	mpleted cause of death (Item 23a)	(Type, Print)	0.0.F.E.		Ja	anuary 22,	2005
_			MARGARITA D.	1000 11	1 Penn	Street, Ba	altimo	re, Man	yland 21	201
	Sta Registr		JAN 2 5 2005	32. Registrar's Signature	eds)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 17, 18 per the 2851 1-18-06 vt.

State of Manual Open timent of Health and Mental Hygiene.

		4	For State Registrer	State of Ma		Atment of Hortificate of L		Re	og. No.	01655	
	Physicia		1. Decedent's Name (First, Middle, Las	0.11	rick			Jan. 18	^h 2005 Year	3. Time of Death	
	/Medic	al	Thomas Vance 4a. Facility Name (If not institution, give		. ICK	4b. City, Town, or	Location of Death		4c. County of Dea		
	Examin	er	Shady Grove Hospi			Rockvi	lle		Montgo	mery	
	Funeral Director		5. Social Security Number 6. Se 349–12–3674	9x 7. Age TYM 2□ F	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 5	, 1923 II	thplace (State or Foreign ountry) Linois	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryla 1 sho	ior	MD Mont go	mery	Potoma	С				1 XYes 2 □ No	
	with the la or 28a-	Direct	10e. Street and Number 11215 Seven Loc	cks Road		10f. Zip Code 2085	4		og. Citizen of What C United Sta		
336	be filed within 72 hours after death with the Maryland stal Hyglene. ad other than "natural", or itams 23a or 28a-f show ad other than "natural", or itams 23a or 28a-f show event, the Madreal Examinar must be notilised at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Ö	72 hou	ted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation Juring most of worl	king	16b. Kind of Business	/Industry	
21215-0036	within 7 ene. than "u	Completed	Elementary/Secondary (0-12)	College (1-4or 5- +5	L)	kind of work done of DO NOT use retired, lege Prof			Educati	on	
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and	hould be f id Mental I markad ol matic eva	To Be	Leon W. Gilpat		n Kimbal (Gilpatrick	Ruth I	ye Cilpa	trick		
Maryland	d 2 s h an 7 ls trau	-	19a. Informant's Name/Relationship (Type, Print) trick/daug!		ng Address (Street a	nd Number or Ru st Road,	ral Route Number Potomac	City or Town, State, MD 2085		
Baltimore,	Pages 1 and innert of Health ant: If item 27 ury or other tr		20a. Method of Disposition 1 Burial			osition (Name of matory or other place ke Cremat		1/05	20c. Location - City o Beltsvill		
altir	permit. Page Depurtment of Important: If any injury or once.		21. Signature Fineral Service Licer		10 \$	2. Name and Address	s of Facility	momotion	Services		
ä	Per la	l B	Manie C	X / TOL	Valle	33 Gist A	venue Si	1ver Spr	ing, MD 2	20910	
Ť			23a. Part f. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause or each lin	the death. Do not en e.	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
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	Examiner		Sequentially list conditions.	b. Ac	a consequence of):	ocardial	Info	irction	^	3 2 245	
-	ited insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Α.	use Re	nal Fa	ilure			3 2245	
Ć.	execu in and ial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence of):	`					
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. Box	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 ☐ Fetal death 3 l	□Ectopic pregnancy			23d. Date of de Month	alivery Day Year	
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Records,	as 2	Completed						24a. Was a autops perform	med? death?	autopsy findings available completion of cause of s	
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of V	Physician: this certificanal director,	ို	1 ☐ Yes 2 ☐ No	Hospital: 1 Impatie			4 Nursing H		ence 6 Other (Sp	ecify)	
	ling After fune	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	Year) 28b. Time (Wor	yat k? Yes 2 ⊡No	200. Describe III	ow injury occurred		
Division	after death. I Diractor: After in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, s				treet and Number or F	Rural Route Number,	
D	2 4 5	erti	4 Homicide determined	building, etc	c. (Specify)			City or Tow	n, State)		
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	To th within To th сопр	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mor		
	1		18/	ml		06	1817	J	annary 19,	2005	
	141	1	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	/_ x		// ***	7.45-	
	100		30. Name and address of person who hahya M. (31. Date filed (Month, Day, Year)	Sharacholo 32 Benistr	u 9901 /	Medical Co	enter Dr.	ve rock	ville, MD	20050	
	St Regist	ate	or. Date med (Month, Day, 16th)	205	H 4	barles					

			For State Registrar	State o	f Marylan	•	artment of H			ene20	05	01656
			Decedent's Name (First, Middle, La.	st)					2. Date of Death	Day	Year	3. Time of Death
	Physici: /Medic		THURMAN	LEWI	I.S		GRAVES		JANUARY		005	2:45 P M
	Examin		4a. Facility Name (If not institution, giv		mber)		, ,	Location of Death		4c. County of Death ANNE ARUNDEL		
			211 WICKLOW AVEN		7. Age (In yrs.	lood birth doub	GLEN BY	JRNLE If Under 24 Hrs.	8. Date of Birth	ANN		JNDEL place (State or Foreign
	Funeral Director			MM 2□F	84	Yrs.	Months Days	Hours Min.	(Month, Day,		Coun	W. Va.
			Usual Residence of Decedent									104 (14-07-11-7-
	ehow	-	MD 10b. County Anne Art	indel	10c. Cit	y, Town or Lo		n Burnie			1	1 ☐ Yes 2 🛣 No
	28a-f	ecto	10e. Street and Number				10f. Zip Code		10	og. Citizen of	What Cour	
	filed within 72 hours after deeth with the Maryland Hygiene. yther then "neturel", or flems 23a or 28a-f ehow ent, the Medical Examiner must be naffiliad at	Funeral Director	211 Wicklow Ave.				21061		"	USA		,
	deeth ms 2;	era	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		ce - Americ	
9	or Ite	F.	1 Never Married 2 Married	Armed For 1 Tyes If Yes, Gi	2 No		1 ☐ Yes 2 ☒ No	Specify:	ricali, etc.)		ick, white, by: whi	
93	urel',	d by	3 Widowed 4 □ Divorced	Year or D	ates:					16b. Kind of E		
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yla	Ment Ment arked	2	Columbus Graves						e Graves			
Maryland	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Mrs. Sandra Pletk		nter		ng Address <i>(Street a</i> D untain Re					Code)
ص ر	1 end Healt Iem 2	1 3	20a. Method of Disposition	, 44461			osition (Name of matory or other place			20c. Location		own, State
OF L	Pages ent of nt: If I	li	1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 💹 Other (Special		State		en Cemete		/05	Glen B	urnie	, MD
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mantal Hygiene. Department if Item 27 is marked other then "neturel; or Items 23s or 28s-f ehow Importent: if Item 27 is marked other then "neturel; or Items 23s or 28s-f ehow any injury or other treatments event; the Madical Examinet must be notilised at once.		21. Signature of Funeral Service Lice	-	M0136	54	2. Name and Address	ss of Facility Sin	ngleton n Burnie	Funera MD 21	1 Hom .061	e P.A.
	_		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that	caused the deat	h. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
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	that the death ned by the atter detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□ Unkr	nant at time of o	leath 5L	Other (specify)					
P.0	that the by detact	y Ph	Part II. Other significant conditions	contributing to	leath but not res	sulting in the u	ındərlying causa gıv	en in Part I.	23e. Did tob	acco use cor	ntribute to t	the cause of death?
rds	quires tha n signed I uld be det	d be	DEMO	ENTI	19				1 □ Y€	s 2 No	3 🗌 Prot	bably 4. Unknown
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no	the factor	tion	27. Manner of Death 1 Natural 5 Pending investigation	(Moi	nth, Day Year)	Injury	Wor	k? Yes 2 □ No	Egg. Describe in	or injury cook		
/isi	Attending in death.	ifica	3 ☐ Suicide 6 ☐ Could not t	e 28e. Plac	e of Injury - At h	ome, farm, st	reet, factory, office	-	28f. Location (St City or Town	reet and Num	ber or Run	al Route Number,
j	s after of Dire	Certification:	4 Homicide determined	build	ling, etc. (Speci	<i>1y)</i>			City or Town	i, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical (miner: On the I			th occurred at the tir nvestigation, in my c					
	To the To the	Me	29b. Signature and title of certifier				29c. Licens	1		9d. Date sign	1 .	/ .
				11.	10		05	5-506		0//	. 4/	12005
	6		30. Name and address of person who	completed cau	ise of death (Ite	m 23a) (Type	, Print)	/ /	2.1.	14		1(2/2)
	,		31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature 4	10 17090	-way	1646	70/	7	end are
	St Regist	ate trar	IAN 2 5 21	005	Muse 1	B A	and I					2005 lend 2120
			8/3:15									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 01657 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Olox A M Stephen John Gaydos /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** A ALTIMO ear If Under 24 Hrs. HG NES HEALTHCARE UVIFIf Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1XXM 2□ F Yrs 1913 Pennsylvania Director 205-05-2618 30, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show 10a, State 10b. County in than "netural", or items 23e or 28a-f show the Modical Expenditure and be collified at 1 ☐ Yes XX No Director Elkridge Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 21075 6011 Montgomery Road America Funeral of 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes XX No Specify: þ 3℃Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Mary Bali Michael Gaydos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If item 27 Is
any injury or other free... Elkridge, Maryland 21075 6011 Montgomery Road; Robert S. Gaydos (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan. 22, MXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2005 Baltimore, Maryland Loudon Park Cemetery 21. Signatore of Funeral Cervin 22. Name and Address of FacilityLoudon Park Funeral Home ricense 3620 Wilkens Avenue Baltimore, Maryland 21229 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSI Physician day /Medical Due to (or as a consequence of). **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Atrial fiberation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Math filled in by the funeral 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Division 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined or A 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ZIHHO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MDZ1229 0 MD 900 HAO

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SIEPEN

ORIGINAL

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Helen С. Hitt January 2005 11:58_A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena
If Under 1 Year | If Under 24 Hrs. 664 C Street Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months 1 ☐ M 2 ☑ F Yrs Director April 25 1930 578-36-6287 Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmet must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ (No Director Pasadena Marvland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 664 C Street 21122 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Collier Sadie Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 664 C Street, Pasadena, MD 21122 Howard L. Hitt (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 1 XBurial 2 Cremation 3 Removal from State 2005 Elkridge, Maryland Meadowridge Cemeterv * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature V Funeral Service Lic. 1 ee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) oncreatic (ances Pnysician Montus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? (es 2 No 1⊡ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 10 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by determined 4 Homicide 24 hours aft te Funerai Di stetely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. mpletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39505 Hospital Dive, Glen Sur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305

DHMH 17 Rev 1/2001

State Registrar egistrar's Signature

2005

Physicia	ın	Decedent's Name (First, Middle, Last) Erionna N. Holliday	2. Date of De Month JANUAF	Day	Year 2005	3. Time of Death 8:47a
/Medica Examine	ar '	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De BALTIMORE CITY			nty of Death	
Funeral Director		5. Social Security Number Control of the security Number Con	Ain. (Month, D	rth ay, Year) 3, 2004	9. Birthp Coul	place (State or Forei ntry) Md.
In show		10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore			1	10d. Inside City Limi 1 Yes 2 ☐ N
23e or 28a-f s	Funeral Director	10e. Street and Number 10f. Zip Code 515 Half Miles Ct 21201		10g. Citizen	of What Coul	-
S 50	þ	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? If Yes, Specify Cuban, Mexican, Pu 1 Yes 2 No Specify:	? (Specify Yes or Nuerto Rican, etc.)		Race - Americ Black, White, ecify:	
tal Hygiene. d other than "natural", event, the Medical Era	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) None	working	16b. Kind of	f Business/In Non	•
d oth	To Be Cor	0	Name <i>(First, Middle</i> Nik	e, Maiden Sum ki McKni		
t of Health and Men If item 27 is marke or other treumatic	⊢ .	19a. Informant's Name/Relationship (Type, Print) Nikki McKnight Mother 19b. Mailing Address (Street and Number or 515 Half Miles Ct Baltimot			wn, State, Zip	o Code)
Department of Health a Importent: If item 27 is any injury or other tre once.	1	20a. Method of Disposition 1 🖫 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery	Date 01/15/05		on - City or To kesville, N	
Departi Import any inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Fu 1300 Eutaw Place	neral Home F	P.A. MD 21217		
ysician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden Unexplained Death in Infair a. Due to (or as a consequence of):	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
Medical caminer	dical Examiner	Immediate Cause (Final disease or condition Sudden Unexplained Death in Infar	diac or respiratory a	arrest,		Interval Between
Medical caminer	edical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Unless Underlying Cause (Disease or injury that initiated events Sudden Unexplained Death in Infar. Due to (or as a consequence of): Due to (or as a consequence of):	diac or respiratory a	arrest,	Date of delivi	Interval Between Onset and Death
Medical caminer	edical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	ncy 23e. Did	23d.	Month contribute to t	ery Day Year
Medical caminer	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	23e. Did 1 24a. Wa auto	23d. tobacco use c Yes 2 \(\text{No.} \) s an 24 posy ormed? 2 \(\text{No.} \)	Month contribute to t o 3 Prot b. Were auto prior to cdegth?	ery Day Year
After this certificate has been signed by the attending physician and mip funeral director, page 2 should be detached for use as the burial-transit and the control of the	To Be Completed by Physician/Medical	Sudden Unexplained Death in Infar Due to (or as a consequence of):	23e. Did 1 24a. Wa auto per 1 12 Yes Death (Check only ng Home 5 Res 28d. Describe	23d. tobacco use c Yes 2 No s an ppsy ormed? 2 No one) sidence 6 o	Month contribute to t o 3 Prot b. Were auto prior to co death? 1 Yes Other (Special curred U	ery Day Year the cause of death? bably 4 \(\frac{1}{2} \triangle
After this certificate has been signed by the attending physician and mip funeral director, page 2 should be detached for use as the burial-transit and the control of the	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Undeathing Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 27c. Manner of Death 1 Inpatient 2 Seb. Time of 2 Sec. Injury at Work? 1 Yes 2 No 2	23e. Did 1 24a. Wa. aut. 24a. Wa. aut. 25g. Death (Check only.) 28d. Describe 28f. Location City or To. Baltime	tobacco use c Yes 2 No Yes 2 No s an 24 posy one) sidence 6 0 how injury occ (Street and No wn, State) ore, Mo e cause(s) and	Month contribute to to to 3 Protection of the Contribute to the prior to endeath? 100 Yes Other (Specificurred under the prior of Rur, 100 Half)	ery Day Year the cause of death? bably 4 Dunkno popy findings availa mpletion of cause 2 No No Reputa Number, Mile Co
When this certificate has been signed by the attending physician and minimizers of should be detached for use as the burial-transit and the state of	To Be Completed by Physician/Medical	Sudden Unexplained Death in Infair Due to (or as a consequence of): Due to	23e. Did 1 24a. Wa. aut. 24a. Wa. aut. 25g. Death (Check only.) 28d. Describe 28f. Location City or To. Baltime	23d. tobacco use c Yes 2 No s an ppsy formed? 2 No one) sidence 6 o how injury occ (Street and N) ove, Mate ore, Mate 29d. Date sig	Month contribute to to to 3 Protection of the	ery Day Year the cause of death? bably 4 Unknot opsy findings availampletion of cause 2 No fy) ink al Rauta Number. Mile Co stated. o the cause(s) Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Holmes 5:00 2005 January 23 rances /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner onens Hopkins Baltimore If Under 1 Year | If Under 24 Hrs. Bayview Medical Ceriter 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 1 M 200 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at NIA Baltimore MD 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Pages 1 and 2 should be filed within 72 hours after death with 1 tment of Health and Mentat Hygiene. 412 N. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, the Medical 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Assistant Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theodore awards Jorothy 19a-Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) neila gaughter Milk m 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 □Removal from State National 21. Signature of Suneral Service Licensee DHILTONHUSS ETILTO. MO 23a. Part Fro the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat - Lause (Final disease of condition resulting in death) Jepsis **Physician** /Medical Due to (or as a consequence of): Examiner piration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Metastatic attending physician and for use as the burial-transit The law requires that the death certificate be executed cancer Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End-Stage 3 Probably 4 Munknown rena disease 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☑Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this Director: After this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To tha Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Baltimore, Avenue Ohameie Mary land Eastern 32. Regis ar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Mary		artment of h		•	giene 20	05 01	662
	Physic /Medi	cal	Decedent's Name (First, Middle, Las HELEN	HARRY	5	4h Ch. Ta		2. Date of De Month JANUA	ry 19,	3. Time o	Death
1	Exami	ner	4a. Facility Name (If not institution, give Northwes' Hosp 5. Social Security Number 6. Se	Ital Cen	yrs. last birthday)	1	r Location of Dea		1	of Death Timore 9. Birthplace (State)	or Foreign
	Director		251-30-4219 Usual Residence of Decedent	□M 2 X F 79	Yrs.	Months Days	Hours Min		y, Year) 25	Country) S.(
	he Marylar 8e-f show	ector	Md. NA	10	c. City, Town or Lo Balt	imore				10d. Inside C	ity Limits
	ath with the same same same same same same same sam	Funeral Director	10e. Street and Number 909 Northhill I				218		10g. Citizen of V USA	Vhat Country?	
900	72 hours after death with the Maryland natural', or Items 23a or 28e-f show aftel Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2🌠 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race Blac Specify	e - American Indian, k, White, etc.	
21215-0036	d within 72 h Jiene. r then "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th grade	ucation fe completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired SE HOME	during most of wo	rking	16b. Kind of Bu	siness/Industry	
Maryland 2	should be filed ind Mental Hygis is marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Clarence	Mea				me (First, Middle, Connie	Maiden Surnam	Weaver	
Baltimore, Maı	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other freumatic event, the Market Examinar must be notified at once.		19a. Informant's Name/Relationship (T) Joann McGriff 20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Daughte 2 Removal from State	er 120 0b. Place of Dispos	natory or other place	nt Valle		altimore 20c. Location -		
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licens			Name and Address		Balti 1101	more, Mo E. Nort	l. 21202 th Ave.	
8760,	cate be executed // Medical fransition and interpretation and interpretations of the burial-transition and interpretation and i	dical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary, leading to minious accase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	nsequence of):	or the mode of dyin	g, such as cardia	C or respiratory and	rest,	Approximat Interval Bet Onset and (ween
.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Y	/ear
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the un	derlying cause give	on in Part I.	i		bute to the cause of do	
Vital Records,	: The law re cate has be ; page 2 sho	Completed						24a. Was a autop perfor	med? pr	fere autopsy findings a rior to completion of caeath?	available ause of
ō	Attending Physicien: The r death. sctor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	^{or:} 4□ Nursing H at	th Check onlow ome 5 Resid 28d. Describe h			
-	- 0	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Number n, State)	r or Rural Route Numb	⊅e <i>r</i> ,
	To the Hospital o within 24 hours aft To the Funerel D completely filled in	Medical	one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occu	and due to the c red at the time, d	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)	
	To To Con	2	29b. Signature and title of certifier	in 3		29c. License	44505		9d. Date signed JOW UAI	(Month, Day, Year) Rig 19, 20	25
	φ		145	impleted cause of death	犯,万.	Print)	- N	wife			
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature						

DHMH 17 Rev 1/2001

ORIGINAL

Security				1- For Amend Item 10f State of Maryland Department of Health and Me Registrar Certificate of Death	ental Hygiei	/ 11 11 1	01663
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Distriction Control C						Baltir	nore
The control of the co				Months Days Hours Min	Month, Day, Ye.	ar) 9. Birth	hplace (State or Foreign untry) RYLMUN
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The second plant of the se		ie Mary Ba-f sh	ctor	MD Harford Forest Hill			
The second plant of the se		with the	Dire	21050	10g.	Citizen of What Co	untry?
15. Decededrift Spale Dependent's Spale Dependent Spale Depend		r death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Cuben Mexican Plants Billion Comments)	ify Yes or No-		
15. Decededrift Spale Dependent's Spale Dependent Spale Depend	036	urs afte al', or li	þ	1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 No Specify:	, 0.0.,		hite
15. Mainter's Name (Prior, Miction, Marce) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close) 16. Mainting Adoress (Street and Number of Plant All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Street All Michael Copy or Town, State, 25 Close (Str	5-0	natural of collection	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business/I	ndustry
18. Montain A name (First, Motobs, Asian Surander) 19. Mailing Address (Street and Number or Paus) 19. Mailing Address (Street and Number or	212	d withir giene. rr than	ошо	College (1-407 5+)	(Vactora	0.00
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Physician (Medical Examiner) The physic	<u> </u>	\$0£ 5 8		Millery y. Duridly PEACHEUL HITERNATTYES	FUNERALO	HAPEL.	
Medical Examiner To grave the property of the property of the part of the property of the part of the		Physician		Immediate Cause (Final			Interval Between
Sequentially list conditions, leaves a consequence of): Comparison of the part of the p		/Medical) =		
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Description of the part of the	Bo	eath ce attend i for use	cian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy			,
Description of the part of the	P.O.	at the d by the	Physi	9 ☐ Unknown 9 ☐ Unknown		2	
Description of the part of the	ds,	uires th signec Id be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
Description of the part of the	ecor	law req as beer 2 shou	plete		24a. Was an	24b. Were auto	opsy findings available
Description of the part of the	al R	r: The cate had page			performed?	death?	
Description of the part of the		ysiciar s certif directo	00	examiner?		6 □Other (Special	6.1
Description of the part of the		ing Ph	Ion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?			(9)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	visio	Attand r death actor: , by the f	ificat	3 Could not be	. Location (Street a	and Number or Rura	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF. IVICOLE BUILDER 9000 Flanth in Square Orive Balt, more MD: 21237 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ö	oital or urs afte ral Dir				i	
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		To th comp	Me				
	•	1		30. Name and address of person who completed cause of death (Item 23a) (Type Print)	Jan	uary, 2	2,2005
		Υ		or Nicole Bullock, 9000 Franklin Square Driv	e Balti	more M	0.21237
169 Star 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 2005 32. Registrar's Signature	ı		

			1- For State of Maryland / Dep	partment of Health and Menta	l Hygie	F 000	01664
			Decedent's Name (First, Middle, Last)	2. Date	e of Death		3. Time of Death
	Physici /Medio		Beulah Howa:	rth Jan		21, 2005	7:08 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Homewood Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Williamsport // If Under 1 Year If Under 24 Hrs. 8 Date	(5)	Washingt	
	Funeral Director		217-01-4567 1 M 2 XF 89 Yrs.	Months Days Hours Min. (Mor	of Birth oth, Day, Ye ch 16,	ar) 9. Birt Co	hplace (State or Foreign untry) MD.
	pc ,		Usual Residence of Decedent		CII 10	, 1915	
	show	٦	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	the M	Director	Md. Washington Hagers 10e. Street and Number				1 ☐ Yes 2 No
	With Se or	Dir	18931 Manchester Dr.	10f. Zip Code 21742	10g.	Citizen of What Co	untry?
	death	Funerai		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	s or No-	14. Race - Ame	rican Indian
9	after or Ite	/Fu	Never Married 2 Married 1 Yes 2X No	If Yes, specify Cuban, Mexican, Puerto Rican, e	etc.)	Black, White	
Ö	hours lurel',	d by	3 Wildowed 4 Divorced Year or Dates:			Specify: VVI	
ر ب	In 72 In 72	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b.	. Kind of Business/l	Industry
212	d with	mo	College (1-40r5±)	pusewife	i	Home	
D	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23e or 28e-f show event, I'm Madical Erain in triust for incitited at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, I		en Sumame)	
<u>y</u>	ould by Ment	To	John Welsh		tone		
Maryland 21215-0036	d 2 sh th and 7 is m treum			ing Address (Street and Number or Rural Route) 31 Manchester Dr.			
ē,	tem 2		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date	20c.	Location - City or 1	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel; or Items 23e or 28a-f show any injury or other treumetic event, the Madical Examinat must be notified at once.		1 X Burial 2 □ Cremation 3 □ Removal from State Oak Lav	wn Cem. Jan. 25 20	15 B	altimor	
ati	rmit. spartm porte y inju						
<u> </u>	89529			2 Name and Address of Facility Connelly Funeral Ho '110 Sollers Point		21222	.K
			23a. Part 1. Enter the disease, of domplications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respira	itory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	(Avica			Sonset and Death
П	/Medical Examiner		Due to (or as a consequence of):				3
		ler	Sequentially list conditions, if any, leading to immediate cause. End under the consequence of): Cause (Disease or injury				
	cuted	Examiner	that initiated events				
Ö,	e exe	Ex	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d				
Š	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			02d Data at dall	
Ď.	death e atter	iciar	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	Day Year
O.	at the de by the a tached	hys	9 Unknown 9 Unknown				
Ś	res tha	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 23e.	Did tobacco	use contribute to	the cause of death?
ecord	w require been signal	eted	ALABERS MACCINAL 1976		1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Rec	has t ge 2 s	ompieted	HMIA FIBRICIATION HY	MATUSEY 24a.	Was an autopsy	prior to co	opsy findings available ompletion of cause of
	10 11	e Co	25. Was case referred to medical	10'	"	death? 1 ☐ Yes	2 🗆 No
5	S S =	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Check of D		0 Flore - 10	
	r Attending Physter death. Irector: After this I by the funeral di	Ju: T	27. Manner of Death 28a. Date of Injury 28b. Time o			ury occurred	(y)
<u> </u>	Attending It death. sctor: After by the fune	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
=	e Hospitel or Attenc 24 hours after death 9 Funerel Director: etely filled in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Local	tion (Street a or Town, Sta	and Number or Rura te)	al Route Number,
	Hospitel Purs S Funerel I tely filled	OL	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only 2 Medical Examinary of the host of my knowledge, death	b coopered at the time of steep and place and during	- 11- /		
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	dicai	(Check only one) 2 Medical Examiner S the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	o the cause(time, date ar	s) and manner as s nd place, and due to	tated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature should dentifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
		2	My Mysican Materia	() (706)	2	av 2/1 2	200
5	11		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	Ha		4
	Stat	0	31. Date filed (Month, Day, Year) Registrar's Signature	TI NUNTIFICATIVE	1144	en Tu	eng
žš.	Registra		JAN 2 5 2005 See & Ago	de	ll	ld 717	747

			For State Registrar	State of Ma	•	partment of r <i>ertificate of</i>			ieme 0 0 5	01665
	e w		1. Decedent's Name (First, Midd	le, Last)				2. Date of Deat Month		3. Time of Death
	Physicia /Medic	_	Mary		High			January	, 23 2	2: 13 AM
	Examin	-	4a, Facility Name (If not institution				or Location of Deat	h f	4c. County of	Death
Ŧ		. 6.	Johns Hopkil		je (In yrs. last birthda	Baltin		R Date of Righ		Pirthplace (Chate or Fernier
	Funeral Director		5. Social Security Number 213-05-0892	1 M 2 F	87 Yrs.	Months Days	Hours Min.		Year)	Birthplace (State or Foreign Country) MD
			Usual Residence of Decedent	•				DCC. Z	1 1317	
	show	_	10a. State 10b. County	1	10c. City, Town or	Location				10d. Inside City Limits
	8a-f s	Director		more	Timon					1 Tes 2 No
	with th	Dir	10e. Street and Number 2117 Folkstor	no Pd		10f. Zip Code	1093	,	0g. Citizen of Wha USA	,
	death with the Maryland ms 23s or 28a-f show rrust te rediffed at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of I If Yes, specify Cub		Specify Yes or No-		American Indian,
٥	after o		1 Never Married 2 Ma	Armed Forces?	No			to Rican, etc.)		White, etc.
2-003p	filed within 72 hours after death with the Marylan I Hygiene. othar then "naturat", or itams 23c or 28a-f show rant, the Medical Evaminet must be multibulat	d by	3 ₩ Widowed 4 □ Divorce			1 ☐ Yes 2 🙀 No			Specify:	white
ה	"natu	ompleted		nt's Education est grade completed)	(G	cedent's Usual Occupive kind of work done a. DO NOT use retire	during most of wo	rking	16b. Kind of Busir	ness/Industry
N	withir Bne. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5	5+)	kkeeper	0)		Furnitu	ıra
D	filed Hyg otha	C	17. Father's Name (First, Middle		1500	киссреі	18. Mother's Na	me (First, Middle, I		
land	9 G T D	Fo B	Stephen Levins	ski			Amelia	Krupins	buch	
Mary	s 1 and 2 should be i Health and Mental itam 27 is markad othar treumatic ev	-	19a. Informant's Name/Relation		19b. Ma	ailing Address (Street	and Number or R	ural Route Number	City or Town, Sta	ate, Zip Code)
ь.	es 1 and 20 Health fitam 27.		Susan L. Cul	p/daughter		7 Folkston				
ore	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 (20a) Cremation		cemetery, c	sposition (Name of crematory or other pla	ce)	Date	20c. Location - Cit	ty or Town, State
пшог			' 4 □ Donation 5 □ Other (.		Meadow	ridge Mem		·k 1/28/0	5 Elkric	dge, MD
n	permit. Departr Imports any inju		(1)	W. Clary	7	Lemmon	Funeral I	Home of I	Dulaney	Valley, Inc.
10	Contract of		23a. Part 1. Enter the disease.	or complications that caused	d the death. Do not	10 W. Pac enter the mode of dyi	donia Rd ng, such as cardia	c or respiratory arm	ium, MD	Approximate
	Physician		Immediate Cause (Final	t only one ause on ach li			weren with	C 1		Interval Between Onset and Death
}	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	we Pulmono	ry Dise	se Tor	٧.	one week
	Examiner		Sequentially list conditions	b. Preun	nania					one werk
	Si si	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				_	
/e0,		calE			, ,					
28	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	ed		0.						
ŏ	eath certific attending p I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregnanc	v		23d. Date of	
n	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at		5 Other (specify)	7		Month	Day Year
j	nat the ded by the detached	Phy	9 ☐ Unknown Part II. Other significant condit		aut ant regulting in th	a undarkina aguar a	una in Bost t	220 Did tot	acco use contribu	ite to the cause of death?
ecords,	ires that signed t	by	_			, , ,		/		Probably 4 Dunknown
5	w require been si	etec	Congestive Head Atrial fibril		12101111	aystunction	`			
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Kec	9 - 9	Ē						24a. Was a autops perforr	y prio	re autopsy findings available r to completion of cause of th?
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Vital R	The ate h page	o Be	Artic stenes 25. Was case referred to medic	<u>ن</u>	ent 2□ER/Outpa	tient 3 DOA		autops perforr 1 □ Yes 2 ath (Check only on	y prio dea 2 12 No 1 =	r to completion of cause of th? Yes 2 No
or Vital H	The ate h page	To Be	Abritic stense 25. Was case referred to medic examiner? 1 Yes 2 No 27. Manper of Death	Hospital: 1 Minpatie	ury 28b. Time	tient 3 DOA Ott	her: 4 🗆 Nursing l	autops perforr 1 Yes 2 ath /Check only on	y prio dea 2 12 No 1 =	r to completion of cause of th? Yes 2 No
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or Vital H	ng Physician: The fler this certificate h meral director, page	To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coulc	Hospital: 1 Impatis 28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injur	e of 28c. Injury	her: 4 Nursing I ry at rk?	autops perform 1 Yes 2 ath (Check only on Home 5 Reside 28d. Describe ho	y price dea 1 le le le le le le le	r to completion of cause of th? Yes 2 No
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	Discoria:		Decedent's Name (First, Middle, I	Last)						2. Date of Dea	th	Vaar	3. Time of Death	
	Physici /Medio		Geronimo Hunt	10.						January	7, 2	2005 ^{Year}	0507 A	М
	Examir		4a. Facility Name (If not institution, g Johns Hopkins Ba		")		Town, or	Location o	of Death		4c. Co	unty of Death		
	Funeral Director		5. Social Security Number 217-90-2844 Usual Residence of Decedent	.Sex 7.A 1□XM 2□F	ge (In yrs. last birti 27	rrs. If Under	Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day 1 - 1 9 - 7	, Year) 7	9. Birthr Cour MD	place (State or Forei ntry)	gn
	/land		10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside City Limit	ts
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36	I, or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2X If Yes, Give Year or Dates:	No	1 ☐ Yes	2 X No	Specify:				ecify:	- 7 '	
ŏ	2 hou	ted	15. Decedent's	Education	16a.	Decedent's Usu	al Occupa	ation				ericar of Business/In-	<u>Indain</u>	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked at the 1 and "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Macilcal Examination must be notified at once.		1 Durial 2 Termation 3	oify)	'	ew Cre	matc	ry/		-05 D	unda	lk. MI		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Hoover 24, January 2005 5:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 109 Nicodemus Road Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Director 213-20-1477 Sept 1, 1910 Maryland Usual Residence of Decedent death with the Maryland 10a. State r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Nicodemus Road 21136 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Caterer Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bennett, Sr. Richard R. Nannie E. Stem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilson R. Bounds Jr. Grandson 3659 Hyser Road Tawneytown Md 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 1/27/2005 Pikesville, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Fune al Service L Reisterstown, MD 21136 Eline Funeral Home 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal **Physician** cell cancer year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The faw requires that the death certificate be executed burial-transit Causa (Diseasa or inju that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 2□ No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 24, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 York Rd, Suite 224, Towson Maryland 21204 Carol New: 11 MD 31. Date filed (Month, 32 Registrar's Signature Registrar Desc.

05-00450 B.K.S JOHN HUBBLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN. 19°3 2005°a 1341 P **Physician** John Delaney Hubble, Sr. /Medical 4b. City, Town, or Location of Death BALTIMORE CITY 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** UNIVERSITY HOSPITAL N/A If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Days Hours Min. 69 Director Sept. 8, Maryland 215-30-9188 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other then "neturel", or items 23a or 28e-f shov treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Lutherville Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2 Brookland Ridge Road USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or item eny injury or other treumatic event, the Medical Eventment once. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Developer Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Laundry L. Hubble Imogene D. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Brookland Ridge Rd. Mrs. Nancy C. Hubble/Wife Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grd. 1/24/05 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or carn shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tu Physician mul disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1X Yes 2 🗌 No To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1∭Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 2 28d. Describe how injury occurred fullially 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: December of Street After Injury 1 Natural 5 Pending 9-05 13:10 Y death. 1 ☐ Yes 2 No investigation Pole struck 2 Accident 3 Suicide within 24 hours after death To the Funerel Director: 6 Could not be determined L cation (Street and Number or Rural Route Number, City or Town, State) WEST FORK IN St 28e. Place of Injury - At home, farm, street, Lectory, office building, etc. (Specify) in by 4 | Homicide VOGO BALTO, MD 21201 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) JAN. 20, 2005 29b. Signature and little g 29c. License number O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201 10 16. 31. Date filed (Month, Day, Year) 32. Register's Signature State 2005 Registrar

REPLACEMENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

a /	Department of Health and	Mental Hygiene
	Certificate of Death	Reg. No. 2005

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel; or items 23a or 28a-1 show any injury or other treumatic event, Item Medical Exercities must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed anding physician and use as the burial-transit within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	,	Cer	tificate of E	Death	F	Reg. No.	005-	01669
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
ın al	Roosevelt L.	Jordan Sr				1	$2\ddot{0}$	2005	3:40A M
aı er	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death		4c. Cou	inty of Death	
	Stella Maris Hos	spice		Timon				Balto.	
П	5. Social Security Number 6. Sex	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3-12-	n /. Year)	9. Birthpl Count	ace (State or Foreign try) MD
	220-20-0011 11	^{4 2□F} 76	Yrs.			3-12-	1928		MD
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	Od. Inside City Limits
5	MD N/A		Baltim						1 XYes 2 No
ect	10e. Street and Number			10f, Zip Code			10g. Citizen	of What Count	trv?
ā	4805 Herring Ru	n Drive		21214			U.S.		,.
era		. Was Decedent Ever in U	J.S. 13. \	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-		Race - America	an Indian,
Fun	1 ☐ Never Married 3 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No	1	f Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)		Black, White, e	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Spe	ocity: Bla	ck
ted	15. Decedent's Educa (Specify only highest grade of		16a. Deced	dent's Usual Occupa kind of work done di	tion	ina	16b. Kind o	f Business/Ind	lustry
nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	DO NOT use retired)	-		Pace	Inter	national
Con	12		Unio	n Organ			Union		
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	T I			18. Mother's Name				
Jo	Charles Edward				Carrie				
	19a. Informant's Name/Relationship (Type			ng Address (Street a					·
	Carrie Jordan (_	Herrin		rive Ba		on - City or Tov	
	1X Burial 2 ☐ Cremation 3 ☐ Rer	moval from State	cemetery, cren	natory or other place)			•	
	' 4 □ Donation 5 □ Other (Specify)			m. Park		-2005			
	21. Signature of Funeral Service Licensee Lloyd M Frstep		É	Step Bro	s. Fun	eral Se	ervic	e P.A	i
	23a. Part1. Enter the disease, or comp			300 Euta				MD Z	Approximate
	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		or the mode of 6, mg	, 02011 20 021 0120	o			Interval Between Onset and Death
	disease or condition resulting in death)	_Adenocaro		of the	Liver				
		Due to (or as a conse	quence of):						
ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						-
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Exa	resulting in death) Last	Due to (or as a conse	quence of):						
Medical	L d.								
led	IS SSWALE.								
	23b. was decedent pregnant	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d.	Date of deliver Month	ry Day Year
Completed by Physician/	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of 9☐Unknown		Other (specify)				WORTH	Day Teal
Phy	9 Unknown		data t ata	-4	- in Book	22a Did ta	bassa usa s	antributa ta th	a agusa et danth?
by	Part II. Other significant conditions contri	libuting to death but not re	suiting in the ui	nderlying cause give	n in Part I.	1 _			e cause of death?
ted						1 🗆 Y	es 2X No	, 3 <u></u>	abiy 4 Donkhown
ple	I					24a. Was a autop	sy	prior to con	sy findings available apletion of cause of
Con						perfor 1 Yes	med? 2∭No	death? 1 ☐ Yes	21XN0
Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	ne)		
Jo	1 105 2 A 140		ER/Outpatier		4 🗆 Nuising no	me 5 Resid			Hospice
ion:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? 'es 2 □ No	28d. Describe h	ow injury oc	currea	
cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injuny - At	homo form str		62 5 140	28f. Location (S	treet and Ni	imber or Rural	Route Number
Medical Certification:	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	oot, ractory, office		City or Tow		or or mural	Joto rydinost,
Š	29a, Certifier 1♥ Certifying Physic	cian: To the best of my kr	lowledge, death	h occurred at the time	e, date and place	and due to the o	ause(s) and	manner as sta	ated.
dica	(Check only 2 Medical Examine one)	cian: To the best of my kr ar: On the basis of examin and manner stated.	ation and/or in	vestigation, in my op	inion, death occur	red at the time, o	late and place	ce, and due to	the cause(s)
Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date sig	ned (Month, D	Day, Year)
	-/4	1		D437	25		1/2	0/2005	5
	30. Name and address of person who com	apleted cause of death (Its	em 23a) (Type		on Allexii			,	
	Tariq Mahmood M				Rd. Timo	onium,	MD 2	1093	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item/19a, per INF G839 1/26/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 18 2005 12:00a^M January JoHnson Mary Consuella /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Pikesville Milford Manor Nursing Home If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 🔀 F MD Director 83 03 216-16-2826 Usual Residence of Decedent 2 should be filed within 72 hours effer deeth with the Marylend end Mental Hygiane. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 ie markad other then "neturel", or iteme 23a or 28a-f ehow other treumatic event, the Medical Examiner must be notified at Yos 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 2315 North Rosedale Street 21216 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3€Vidowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Clerk U.S. Government 12tH grade permit. Peges 1 and 2 should be file Deperment of Health and Mental Hy, important; if Item 27 Is marked other any Injury or other than 18 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matilda Goldring Leroy West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) Roxanne Johnson Daughter Roxanne Jefferson Daughter 8807 Stone Ridge Circle, Pikesville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/27/05 Owings Mills, Md Garrison Forest Vet. * 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 mer 23a. Part1. Ent. — e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** end-stage copD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease of it jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) tha detached 9□ Unknown 9 Unknown vare nas been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2□No Physician: ours efter death.

neral Diractor: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Medical Certification; To 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) or Attending 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier NSKeyapahaem.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main Street, Reisterstann, Suite 200 . S. Kajapakse, MI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of N	Maryland / Dep	partment of e <i>rtificate o</i>		and Mental	Hygiei Reg.	C 000	01671
	- · · ·		1. Decedent's Name (First, Middle, La	ist)				2. Date Mont	of Death h	Day Yea	3. Time of Death
	Physici /Medio		CATHERINE ANNA	JANOWITZ		,		JAN	JARY	24, 200	5 12:12 A.M
	Examir		4a. Facility Name (If not institution, give	e street and numbe	r)	4b. City, Town,		f Death		4c. County of D	
			1760 JOAN AVENUE			PARKV.		24 Hrs. I o D	- (D: a)	BALTIM	
	Funeral		5. Social Security Number 6. S	Sex 7.7 1□M 2□xF	Age (In yrs. last birthda Yrs.	Months Day		Min. (Mon	of Birth h, Day, Ye	ar)	Birthplace (State or Foreign Country)
	Director		217-16-5216 Usual Residence of Decedent	2.	83			5/18	3/192	1 M	ARYLAND
	land		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	f sh	Ď	MD BALTIMO	DRF:	PARKVIL	J.E					1 ☐ Yes 2 🔀 No
	1 28e	rec	10e. Street and Number	71 GD	111111111111111111111111111111111111111	10f. Zip Code)		10g.	Citizen of What	Country?
	s after death with the Marylan , or Items 23a or 28e-f show coniner must be notified at	Funeral Director	1760 JOAN AVENUE	r		212	34			USA	
	death ms 2	Jera	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	. Was Decedent of		gin? (Specify Yes	or No-		merican Indian,
9	or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 E	Į No	1 ☐ Yes 2 ☒ N		, rueno moan, en	,		rinte, etc.
8	ours,	ğ	3 ₩ Widowed 4 Divorced	Year or Dates	:	12.03 2 <u>M</u> 10				Specify: WI	HITE
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show ta Modical Examiner must be notified at	Completed by	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Giv	edent's Usual Occ e kind of work don	e during most	of working	16b	. Kind of Busine	ss/Industry
21	han ithin	m jd	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NDT use retir	rea)		0.	DI HOMB	
	be filed within tal Hygiene. d other than event, the M.		7TH GRADE 17. Father's Name (First, Middle, Last	•)	НС	MEMAKER_	18 Mothe	r's Nam <i>e (First, M</i>	, -	WN HOME	
anc	0 5 0 0	Be	CHRISTOPHER BEH					RTLE FINI		,	
Ž	2 should be f and Mental I Is marked of sumatic eve	ို	19a. Informant's Name/Relationship (19b. Ma	ling Address (Stree				v or Town. State	a. Zip Code)
Maryland			MARK JANOWITZ	SON		CATON R		AMPSTEAD		21074	
	s 1 and if Health item 27 other to	1	20a. Method of Disposition	501	20b. Place of Dis	position (Name of		Date		Location - City	or Town, State
ō	Pages nent of int: If it	١,	1 ☐ Burial 2 ☑ Cremation 3 [0	ematory or other p		1/26/2001	5 00	YANSUTI I	E MD
		1	*4 □Donation 5 □ Other (Special Service Lice								HOME, P.A.
Ba	permit. Departrimports any inju		Leath. U	Hered		8521 LOC					21286
			23a. Part1. Enter the disease, or com	plications that caus						.,	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		TE MYE	2010 L	EUKE	MIH			
	Examiner			_ '							
		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	us a consequence of):	אזאטקכ					
. 1	unsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_		n G LLITU	IS TY	PC 2.			
8760, <	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	that initiated events resulting in death) Last		as a consequence of):			-			
292	ate be nysicia he bur		, ,	d							
.89	ificate g phys as the	Physician/Medical	101								
Вох	leath certifica attending ph I for use as th	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Estania aragga				23d. Date of	delivery
m.	death e atte d for	icia	in the past 12 months?	4☐Pregnant	at time of death 5	☐ Ectopic pregnan☐ Other (specify)				Month	Day Year
P.0	at the de by the a tached	hys	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown							
·,	res tha igned i be det	by P	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause g	given in Part I.	23e.	Did tobacc		to the cause of death?
rds	w require been sig should b								1 🗌 Yes	2,25(No 3□	Probably 4 Unknown
of Vital Records,	law requ as been 2 should	Completed						24a.	Was an autopsy	24b. Were	autopsy findings available to completion of cause of
æ	The is ate ha page 2	E						10	performed	2. death No 1 ☐ Y	? es 2□ No
ital	ı ician: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place	of Death (Check			
>	di S	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpa	tient 2 ER/Outpati	ent 3 DOA	other: 4 🗆 Nur	rsing Home	Residence	6 □Other (S	pecify)
	ding Ph th. After thi funeral		27. Manner of Peath 1 Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 28b. Time Day Year) Injury	of 28c. In	ury at lork?	28d. esc	ribe how in	njury occurred	
Division	Attending ir death. ector: After by the fune	Certification;	2 ☐ Accident investigatio			M 1	☐Yes 2☐N				
<u>X</u>	ol or Attend after death Director: , d in by the f	ţį	3 Suicide 6 Could not be determined	286. Place of I	njury - At home, farm, s etc. (Specify)	treet, factory, office	е	28f. Local City of	ion (Street or Town, St	and Number or ate)	Rural Route Number,
0	itel or urs afte ral Dir lled in										
	e Hospitel 124 hours a 16 Funeral C	edical	(Check only 2 Medical Exa	miner: On the basis	st of my knowledge, de of examination and/or	ath occurred at the investigation, in my	time, date and opinion, deat	d place, and due to th occurred at the	the cause time, date a	e(s) and manner and place, and d	as stated. lue to the cause(s)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medi	one)	and manner	stated.		nse number			Date signed (Mo	
	To the within:		29b. Signature and title of certifier Your Www	Mail				a 1	01	,	O ST
							2553	U J		! - 11	
	10		30. Name and address of person who				5-100	MD	212	04	
	10			1416	STREET.		3 , 00				
		_	31. Date filed (Month, Day, Year) JAN 25	2005	State Registrar 31. Date filed (Month, Day, Year) AN 2 5 2005 32. Registrar's Signature.						

		•	State of Maryland / De	epartment of Health and No Certificate of Death	•	me 0 0 5	01672
H	Physicia	an	Decedent's Name (First, Middle, Last) Nelson Kyle	ar	2. Date of Death Month	Day Year	3. Time of Death 6:35 am M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 2522 Huron Street	4b. City, Town, or Location of Death		23, 2005 4c. County of Death	
	Funeral Director		5. Social Security Number 213-09-7175 6. Sex 1 □ M 2 □ F 100 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Apr 4, 19		place (State or Foreign htry) Maryland
	e-f show	ctor	Usual Residence of Decedent	r Location Baltimore		1	10d. Inside City Limits 1 Xes 2 No
	with the	i Dire	10e. Street and Number 2522 Huron Street	10f. Zip Code 21230	10g	Citizen of What Could. U.S.A	•
250	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other then "naturel", or Items 23e or 28e-f show other treumetic event, its Medical Examinations to notified at	by Funeral Director		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
D-C 7	within 72 hou ene. then "nature the Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of work fe. DO NOT use retired) Porter	ting 16	b. Kind of Business/In	
yialiu z	ould be filed Mental Hygi arked other stic event, I	To Be Co	17. Father's Name (First, Middle, Last) Joe Kyler	18. Mother's Nam	e (First, Middle, Mai Gei	iden Sumame) trude	
Z	id 2 sho Ith and 27 Is ma treume		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) 19b. N Irene Waverly	failing Address (Street and Number or Rui 2522 Huron Street Baltimore			Code)
์ เก	8 = 5		20a Method of Disposition 20b. Place of D	crematory or other place)	Date 20	c. Location - City or To	
	permit, Pa Departmen Importent: any injury		21. Signature of Funeral Service Usensee	22. Name and Address of Facility			,
Ç F	Physician /Medical Examiner	Je.	resulting in death) Due to (or as a consequence of)	ation Preumonia	or respiratory arrest	2121/+-	Approximate Interval Between Onset and Death
	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	dical Examiner	b. Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) c. Due to (or as a consequence of)	:			`
.O. BOX 00	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	***	23d. Date of delive Month	ery Day Year
cords, r	tuires thai n signed t	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		cco use contribute to t	he cause of death?
		Completed				prior to co	opsy findings available impletion of cause of
sion of Vitas	ng Phy Iter this Ineral d	ation: To Be	25. Was case referred to medical examiner? 1	atient 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 X Residence 28d. Describe how		y)
	el or Atte s after de el Directo ed in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, control on the basis of examination and/one and manner stated.	or investigation, in my opinion, death occur	red at the time, date	and place, and due to	o the cause(s)
	vithir comp	W	29b. Signature and title of certifier V.M. M. M. Lell, M.D.	29c. License number MD 61504	29d	. Date signed (Month, JANUARY 2	
1	NY			nover street, Balling	ire, MD	21225.	
	Sta Registi		31. Date filed (Morth Ray, 20a) 2005 32. Agistrar's Signature	South >			

DHMH 17 Rev 1/2001

ORIGINAL

KHICHTON, JANES C Baltimore, Maryland 21215-0036

Baltin	permit. Pa	Departmer	eny injury	once.
	/[ysi Med am	dic	al
7	ted		nsit	

Division of Vital Records, P.O. Box 68760

		State of Maryland / Department of Health and		
		1 State Conficients of Death		ieg. No.
		1. Decedent's Name (First, Middle, Last)	2. Date of Deat	
Physicia		James Christopher Knighton	JALLICIC	21 2000 2330 M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	1-1	4c. County of Death
LXdillii	CI.	St. Agres Hospital Baltingle		N/A
Funeral		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs		, Year) 9. Birthplace (State or Foreign Country)
Director		220-82-6569 42 Yrs.	SEP 15,	
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Aaryla F sho	٥			1 ☐ Yes 2 🎇 No
the A	Director	Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code	1	Og. Citizen of What Country?
filed within 72 hours after death with the Maryland Hygiene. Hygiene then "naturel", or Items 23e or 28e-f show ont, the Medical Examinar must be notified at	<u>ה</u>	11 S. Beechwood Avenue 21228		USA
ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
after or Ite	Fu	1 ☐ Never Married 2 1 X Married 1 ☐ Yes 2 No	to Rican, etc.)	Black, White, etc.
ral',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: White
J within 72 ho piene r than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking	16b. Kind of Business/Industry
han han	mp	Elementary/Secondary (0-12) College (1-4or 5+)		
iled v tygie ther t		4 CPA/Partner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Middle, I	Accounting Maiden Sumame)
ntai h ed ol	Be			McGreevy
2 should and Men la marke aumatic	ပ္	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri		
s 1 and 2 should be filed within the Halth and Mental Hygiene. Item 27 la marked other than other traumatic event, I'm M.		Michele Denise Knighton/wife 11 S. Beechwood Avenu		*
permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other trat		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Pages nent of I int: If ite		1 Burial 2 ACremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 101/2	4/05	Baltimore, MD
ortar inju		21. Signature of Fundinal Service Licensee 22. Name and Address of Facility Ciemation Society		
g g g g g		Davi F. McDonald 299 Frederick Roa	d Baltin	more MD 21228
		23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arre	est, Approximate Interval Between
Pnysician		Immediate Cause (Final		
/Medical		disease or condition resulting in death) a	rioce	Tinenin
Examiner		Sequentially list conditions b.		
י ד	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
scute ind trans	Examiner	that initiated events C.		
s be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
w - w	dical	d		
The law requires that the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		73d Date of delivery
atten for us	ian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
the d	ysic	1 Yes 2 No 9 Unknown		
that the de ned by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	bacco use contribute to the cause of death?
uires n sign	d by		1 □ Ye	es 2 No 3 Probably 4 Ninknown
w requir s been s should	iete		24a. Was a	
The lav	Completed		autops perform	prior to completion of cause of death? 2 No 1 Yes 2 No
	0		ath (Check only on	7
Phyalcian: r this certifice ral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 Reside	ence 6 Other (Specify)
ig Ph ter th		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe ho	ow injury occurred
endir oath. or: Af	atic	2 Accident investigation M 1 Yes 2 No		
r Att ter de irect	Certification:	3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
urs af			,	
To the Hospital or Attending Phyalcian: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the ca arred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
thin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier. 29c. License number	25	9d. Date signed (Month, Day, Year)
To with		Le Cole MD D16354		1/22/2005
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		112000
10		EW COLE STAGNES 900 CATON AVE B	ALTIMO	2E MD 21229
Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		
Registra		JAN 2 5 2005 Boeine & April 2		

			For State Registrer	State of Maryl			of Healt			ene 0 0 5	01674
			Decedent's Name (First, Middle, Last	t)					2. Date of Death	1	3. Time of Death
	Physicia		Lakshmi N	arayan	Kailasa	am			Month January	Day Year 20,2005	3:35 P ^M
	/Medic		4a. Facility Name (If not institution, give		Rallas		own, or Local		oanaar y	4c. County of Dea	
	Examin	er	Holy Cross Hospi					Spring		Monto	gomery
	Ć		5. Social Security Number 6. S		yrs. last birthday)	If Under 1	Year If Ur		B. Date of Birth (Month, Day,	<u></u>	thplace (State or Foreign
	Funeral Director			Мм 2□F 8	4 Yrs.	Months	Days Hou	urs Min.	an. 15	1921	intry) [ndia
			Usual Residence of Decedent								
	yland		10a. State 10b. County	10c	. City, Town or Lo						10d. Inside City Limits
	Mar Mar	tor	Maryland Montgo	mery		S	ilver	Spring			1 ☐ Yes 200 No
	r 28e	Director	10e. Street and Number			10f. Zip (Code		10	g. Citizen of What Co	ountry?
	3a o		10708 Huntwood D	r.			2090	1		Indi	ia
	deati ms 2	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decede	ent of Hispani	c Origin? (Spec xican, Puerto R	ify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
9	after or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No			•		ican, etc.)		
<u>Ö</u>	el', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 Yes 2	No Spe	эспу:		Specify: As	sian Indian
Ó	within 72 hours after death with the Maryland one. Itan "naturel", or Items 23a or 28e-f show the Modical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual	Occupation	most of working		6b. Kind of Business	Andustry
212	thin	ρle	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)		, i		
2	e filed within al Hygiene. I other than "	on		5+		Geophy	sicist				t of India
밀	be filed ital Hygi id other event, II	Be (17. Father's Name (First, Middle, Last)							laiden Sumame)	
<u>Ja</u>	uld b Ment wrkec	2	L. A. Na	ırayan İye	er			C. K.	Chellan	nal	
Maryland 21215-0036	2 should be and Mental Is marked of eumatic ev	13	19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •		-				City or Town, State, .	0 -
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Mental Hygiens. If the m 27 is marked other than "naturel; or thems 23a or 28e-1 show it it them 27 is marked other than "naturel; or there must be roullified at or other treumatic event, it is Modical Examinating must be roullified at		Prakash Narayan/								20901
Baltimore,	of He		20a. Method of Disposition	- 1	b. Place of Dispo cemetery, cre	osition (Name matory or oth	e of her place)	Da	ite 2	Oc. Location - City or	Town, State
Ĕ	Page nent: M		1 ☐ Burial 2 XCremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Chesapea	ke Cre	ematory	1/21/	05	Beltsvil	le, MD
att	permit. Pages 1 Department of H Importent: If Ite any Injury or ot once.		21. Signature of Funeral Service Lider	isee	2:	2. Name and	Address of F	acility	comation	Services	
m	S O E E		Statut John	mann Mo					emation er Sprir		910
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the							Approximate Interval Between
	Physician		Immediate Cause (Final		ai o						Onset and Death
	/Medical		disease or condition resulting in death)	a. Pneumor							
	Examiner			b Sepsis							
	φl	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):						
	d ansit	Examine	cause. Enter Underlying Cause (Disease of Inflat) that initiated events	c. Hyperte	ension						
	exec n and ial-tra	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):						
8760,	icate be executed physician and s the burial-transit	dicai		Cerebro	ovascula	r Acci	ident				
.89	ficate g phy is the	a									
Вох	the death certific y the attending p Iched for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		7				23d. Date of de	livery
ĕ	death atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		⊒Ectopic pre ⊒ Other <i>(spe</i>				Month	Day Year
O.	that the de ted by the a detached t	ysi	9 Unknown	9□ Unknown							
Δ.	The lew requires that ite has been signed b page 2 should be deta		Part II. Dther significant conditions of	ontributing to death but no	t resulting in the u	inderlying ca	use given in f	Part I.	23e. Did tob	acco use contribute t	the cause of death?
Records,	uires sign ld be	d by							1 ☐ Ye	s 2√√No 3□P	robabiy 4 Unknown
Ö	w requir been si should	Completed							24a. Was an	24b Were a	utopsy findings available
3e(has has	шр							autopsy	prior to	completion of cause of
<u></u>										A	2 □ No
Vital	Physiclan: This certificated director, p	Be	25. Was case referred to medical examiner?	Hospital:			Other		(Check only one		
ō	Phys this ral dia	2	1 ☐ Yes 2 X No 27. Manner of Death	1 X Inpatient 28a. Date of Injury	2 ER/Outpatie		71			nce 6 □Other <i>(Spe</i> w injury occurred	cify)
L C	ling After unel	<u>o</u>	1 XNatural 5 ☐ Pending	(Month, Day Yea	ar) Injury	M	3c. Injury at Work? 1 ☐ Yes		30. 20001120 110	w mjary occanios	
Sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not b		At home farm et				Rf Location (Str	eet and Number or R	ural Route Number
Division	il or Attend after death Director:	Certification;	4 Homicide determined	building, etc. (S	pecify)	ieet, tactory,	, orne		City or Town		ara riodio rranson,
	urs a		COn Contilion 1 M Continue Ph	veision. To the best of au	. Isaassi odaa daa	th conversed on	t the time do	to and place or	nd due to the ee	uso(a) and manner a	r stated
	e Hospital 24 hours a Eunerel etely filled	lica	29a. Certifier 1 Certifying Ph (Check on 2 Medical Exar	ysicien: To the best of my niner: On the basis of examiner and manner stated.	mination and/or in	ivestigation,	in my opinion	, death occurre	d at the time, da	ite and place, and du	e to the cause(s)
	To the Hospital or Attent within 24 hours after deati To the Funerel Director: completely filled in by the	Medical	29b. Signature and title of certifier	uno marmor stated.		29c.	License num	ber	29	d. Date signed (Mon	h, Oay, Year)
	F 3 F 8		/ XL S.	SHAMIM		Anna anna	D5928	3/1	1	01/20 t	2005
	611	2	7		(ha= 00-) =	Deie *\	77740) -1		1 -0 1	-
	12/10		30. Name and address of person who				C ± 1-	ion Cara	ing MD	20910	
			Ahmad Shamim I	1. D.; 8600 FO	orest GL Signature	en Kd.	., 5117	ver Spri	mg, mu	20310	
	Sta Registr		31. Date filed (Month Pay, Year)	2005 Cores	Signature	park					

JOHN KOPP

		1 - State Registrar	State of Marylan		tificate of D		R	eg. No.	01673
Physic	cian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death 2:25 P M
/Med Exam	lical	John Ulrich Kopp 4a. Fecility Name (If not institution, give st			4b. City, Town, or	Location of Death	Jan.	19 2005 4c. County of Deat	
Exam	mei	Stella Maris			Timor			Baltimo	re
Funera Directo		5, Social Security Number 6. Sex 215-14-9803	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day July 4	Year) Co	nplace (State or Foreign untry) yland
Maryland f show	tor	Usual Residence of Decedent		y, Town or Lo Timoni					10d. Inside City Limits 1 ☐ Yes X☐ No
death with the Maryland rms 23a or 28a-f show	I Director	10e. Street and Number 2306 Wuthering R	d		10f. Zip Code	1093	1	0g. Citizen of What Co	untry?
P 25 25	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
A IX I 3-0030 d within 72 hours af glene. sr than "natural", or toe Woolcal Exam	Completed b	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give life.	dent's Usual Occupa kind of work done do DO NOT use retired)	tion uring most of worki	ing	16b. Kind of Business/	Industry
d with d with glene.	lmo	Elementary/Secondary (0-12)	College (1-4or 5+) n/a	Vice	Presiden	t of Sale	s	Constructi	on
yland Z buld be filed Mental Hygid arked other atic event, u	Be	17. Father's Name (First, Middle, Last) Andrew Kopp				18. Mother's Name Margar	et Meng		
Shoul nd Me mark	5	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	I Route Number	r, City or Town, State, 2	Zip Code)
ore, Marylal so 1 and 2 should b of Health and Ment litem 27 is marked		Carol Klingenberg/	daughter	_		The second second second	Valley,	MD 21030	
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		sition (Name of matory or other place Valley Me	1 1 / 4 1	/05	20c. Location - City or Timonium,	
permit. Pages Department of I Important: If ite		21 Souture of Funeral Wife Vons		20	Name and Address	ol Facility		ulaney Val	
		23a Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	h. Do not ent	er the mode of dying	, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
Physiciar /Medica	ı I	Immediate Cause (Final disease or condition resulting in death)	COLON CANCE Due to (or as a conseq						Onset and Death
Examine		Sequentially list conditions, b.	Due to (or as a conseq	uence of):					
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
56 / 50, Illicate be executed g physician and as the burial-transit	al Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
68 / 60, ificate be example of a physician as the buria	edical	d.							
death cer death cer e attendin d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
det hat	Š	Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	1	bacco use contribute to es 2 ☐ No 3 ☐ Pr	the cause of death?
_ ~ ~	Completed						24a. Was a autop: perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of 2 \(\sum \) No
t VITAL II Nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death			
Phys r this	lon: To	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1 28c. Injury Work	at		ence 6 X Other (Spe ow injury occurred	cify) HOSPICE
	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, larm, st (y)		-	281. Location (S City or Tow	treet and Number or Ru n, State)	ural Route Number,
Hospita 24 hours Funeral stely filled	edical C	29a. Certifier 11 Certifying Phys (Check only one)	trien: To the best of my kno er: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the cred at the time, c	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title ol/certifier			29c. License	number	2	29d. Date signed (Mont	h, Day, Year)
->-0			15-		かし	13725		1/19/0	05
KY		30. Name and address of person who con						/ //	
')	100	DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)	2300 DULAN 32 egistrar's Signa		LEY RD.	TIMONIUM,	MD 210	93	
Regi	State strar	JAN 2 5 200		K A	. 10				

			For State Registrar	State of Ma	ırylan	•	artment rtificate			and M		giene Reg. No.	05	016	76
	Physici	an	1. Decedent's Name (First, Middle, Las		2. Date of Death Month					Day	Year	3. Time			
	/Medic	ai	MARVIN 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER				KIRSCH		Location of	4 Death	JANUARY		20, 2005 1:15 P ^M		
4	Examin	er						TIMOF)i Death		4c. County of Death BALTIMORE			
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs.	last birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Birt		9. Birt	hplace (State untry)	or Foreign
	Director			X 2 F	83	Yrs.	Months	Days	riours	WIII.	8. Date of Bird (Month, Da DEC.8,	1921			MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or L	ocation							10d. Inside	City Limits
	Marylan -f show	ţ	MD BAL	ΓIMORE		BALT	IMORE							1 🗋 Ye	s 2 No
	n the	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Co	untry?	
	23a c	raiD	6618 SANZO ROAD						2120					USA	
	er dea	nue	11. Marital Status	12. Was Decedent B Armed Forces?		S. 13.	Was Deced If Yes, sp <i>ec</i>	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	- 14. R	Race - Ame Black, White	rican Indian, e, etc.	
36	irs after	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	∘ ww. ARi		1 ☐ Yes 2	No X	Specify:			Spec	cify:	WHIT	E
21215-0036	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show dical Examinar must be notified at	ted	15. Decedent's Ec			16a. Dece	dent's Usua kind of wor	l Occupa	tion	t of work	ina	16b. Kind of	f Business/	Industry	
21	c = 30	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT us	e retired)			9	1,11,01,54			
	be filed within 72 ho ital Hygiene. id other than "neture event, Ire Medical		17. Father's Name (First, Middle, Last)			SALES	REPR	ESEN			e (First, Middle,	WHOLES			
Maryland	should be filed within a Mental Hygiene. marked other than matic event, Ite M	To Be	GEORGE			KIRS	CHBAU	М	DOR/		,		,	ABRA	MS
ary	·	-	19a. Informant's Name/Relationship (Туре, Print)			_		nd Numbe	or Or Rura	al Route Numbe	-		Tip Code)	
	1 and 2 Health a em 27 is ther trai		NADINE KIRSCHBA	JM / WIFE	1	And the second second			AD #C		BALTIMO				
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	0	lace of Disperent of the desired of	matory or ot	her place			Date	20c. Locatio			
Ë	Pa nt:		* 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licentation 21.	- 1	HEB	REW YO					1/2005		DLAWN		
Ba	permit. Departm Imports any inju		DANH M	attle	,						LEVINS				กร
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death								,	Approxim Interval B	ate
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition	MALL	6 NI	way	M	6	-UN	16				Onset and	
			resulting in death)	Due to (or as	conseq	uence of):								1 40	WE.
	LAGIIIIICI	<u></u>	Sequentially list conditions,	equentially list conditions,			or as a consequence of):								
	ate be executed obysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury												
Ć			that initiated events resulting in death) Last	Due to (or as a	conseq	uence of):									
8760		ical		d											
9	death certifica attending ph for use as the	Physiclan/Med	IF FEMALE:	Olo Hugo sutesmo	of acama										
Вох	attenc for us	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 🗌 Feta	Ideath 3[☐Ectopic pro☐Other (sp						Date of del Month	Day	Year
o.	that the dead by the detached	nysic	1 Yes 2 No 9 Unknown	9☐ Unknown		Jun 0		Jo., y ,							
S, D	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	by PI	Part II. Other significant conditions of	ontributing to death bu	it not res	ulting in the u	ınderlying ca	ause give	n in Part I.		23e. Did to	obacco use co	ontribute to		/
Records,	w require been sig should t										10	Yes 2□No	3 🗆 Pr	obably 4	Unknown
leco	e fawr has be je 2 sh	Completed	- 4-								24a. Was autor		b. Were au prior to death?	topsy finding completion of	s available cause of
											1 Yes	2000	1 🗆 Yes	2 No	
Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatie	nt 3 DO	Δ Othe			h <i>(Check only c</i> me 5 ☐ Resid		Other (Sne	cifu)	
o of	Attending Physician: r death. ector: Atter this certifics by the funeral director, i		27. Mann of Death	28a. Date of Injur (Month, Day	v	28b. Time of		Bc. Injury Work			28d. Describe I			ony)	
io	ittendin death. ctor: Aft / the fur	atlo	1 Natural 5 Pending 2 Accident investigatio	n	, ош,	injury	М		res 2□	No					
Division	l or Att after de Directe	Certification:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify									et and Number or Rural Route Number, State)		
	pital	I Ce	29a. Certifier 1 to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	To the Hospital or Atten within 24 hours after deal To the Funeral Director: completely filled in by the	edical		niner: On the basis of and manner sta	examina										(s)
	To th withir To th comp	3	296. Signature and title of certifi-				29c	. License	number	1. 11		29d. Date sig			_
•	1018	-/	for or	nolno	1	W.		1/	177	40		1/1	V - 上	1200	2
1	10		30. Name and address of person who	completed cause of d	ath (Item	23a) (Type	Plint)	HE	Bu	01	SAT	JAM MO	21	2/6	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	iture	1000		101	7		- V	010	()	
	Regist		JAN 2 5	2005 Je	Sec.	Ji.	Spark	2		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 1:15 **Physician** Leight January В. Virginia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena 2162 Lake Drive If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** PA1 ☐ M 2 🖫 F 80 Yrs. 209-20-3793 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Pasadena Anne Arundel Funeral Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or USA 21122 2162 Lake Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel; or ite 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2X No 1 Yes 2 No White Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Household Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emily Pearce Brinton Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2162 lake Drive, Pasadena, MD 21122 (spouse) William E. Leight Date 22 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. permit. Pages 'Department of himportent: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Timonium, Maryland 4 Donation 5 Other (Specify) Valley MemGar Dulaney 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease shock, or heart failure L Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Alzheimus io yrs **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ō 4☐ Pregnant at time of death 5 ☐ Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physicien: 26. Place of Death (Check only one) To Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 Yes 2 X No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Ti Pendina 1 ☐ Yes 2 ☐ No investigation death. Director; / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a
To the Funerel C TSC Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

JAN 2 5 2005

Michael Downin

31. Date filed (Month, Day, Year)

30. Name and address of person who completed plause of death (Item 23a) (Type, Print)



MO

D50108

Olenburnin MD

2005

			For State Registrar	State of Marylan	d / Dep <i>Ce</i>	artment of Hertificate of L	ealth and M Death		2005	01678				
	Physici /Medic		Decedent's Name (First, Middle, Last)	Mary L	_ewis			2. Date of Death Month Jan	Day 19, 2005	3. Time of Death 11:05 Pm. M				
	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or	Location of Death Severna	a Park	4c. County of Death Anne Arundel Co.						
	Funeral Director		5. Social Security Number 6. Sex	nesis Eldercare 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Feb 27, 1	9. Bir 916	thplace (State or Foreign buntry) Maryland				
	/land	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	y. Town or L	ocation				10d. Inside City Limits				
	e Man	ctor	Md	Bal	timor	:e			<u> </u>	XXYes 2□No				
	with th	Dire	10e. Street and Number	1		10f. Zip Code		10g	. Citizen of What Co U.S					
	ms 23	Funeral Director	1117 Race Stree	12. Was Decedent Ever in U.	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame					
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ha Medical Exam at must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	+	1 ☐ Yes ZX No	Specify:	Rican, etc.)	Black, Whit					
15-0	n 72 h	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. Dece (Give life.	edent's Usual Occupa e kind of work done d DO NOT use retired;	ation Juring most of works)	ing 16	b. Kind of Business	/Industry				
212	d withi giene. er than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Lau	indress		I	Laundry	Company				
	be file stal Hy od othe event,	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)					
Maryland	should nd Mer marke	2	Haghie Burley 19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	ing Address (Street a	Mattie I		City or Town, State, 2	Zip Code)				
	and 2 salth er alth er 27 is er treu		Morustine Hill		100	003 Little Bear								
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Exam net must be multical appres.		20a. Method of Disposition 1 → Rurial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)		emetery, cre	osition (Name of matory or other place On	9)		c. Location - City or andsdown					
Balt	permit. Depertimport		21. Signature of Fuheral Service License	Sty		1300 Eu	others Funer taw Place Ba	al Home P.A. altimore, MD.2						
Ļ			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death	n. Do not en	nter the mode of dying	g, such as cardiac o	or respiratory arrest	,	Approximate Interval Between Onset and Death				
	/Medical		23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):											
	Examiner		Sequentially list conditions,	AMERIOS	cue	notic	CANDI	orase	JAR					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence or):			り(.	31792					
, 0,	icate be executed physicien and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):			7						
38760,		edical		1										
P.O. Box (The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100 0 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year				
	quires that n signed b uld be deta	þ	þ	þ	by	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	underlying cause give	en in Part I.		cco use contribute lo	the cause of death?
Records,	The law require rte has been sli age 2 should t	Completed						24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of				
Vital		Be C	25. Was case referred to medical examiner?				4	(Check only one)						
of	문 등 F	2	1 Yes 2 100	lospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie		4 Nursing Ho		e 6 Other (Spe	cify)				
ion	Attending Physician: or death. ector: After this certific by the funeral director.	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		28c. Injury at Work? 1 □ Yes 2 □ No							
Division	al or Atter s efter des il Director sd in by th	Certification;	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)							ural Route Number,				
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.										
,	To the troop	W /	29b. Signature and title of certifier	is mp		29c. License	776	J F	Date signed (Mont	h, Day, Year) 21, 2005				
1	1		30. Name and address of person who co	RAMO 30	23a) (Type	Print)	VBL 5-1.	BALTI	MUNE	ND 2625				
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 200	32. Segislrar's Signa		reall .								

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland 1 - State Registrer	/ Depa		ealth and	Mental Hyg	_	5 016	79	
	o Physici	an	1. Decedent's Name (First, Middle, Last) Helen Ursula Lennon				2. Date of Deat Month	Day	Year 3. Time of		
/Medica Examine			4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	4b. City, Town, or Location of Death			4c. County of Death		
	Examin	ier	Riva Terrace II Assisted Living		Annap			Anne Arundel			
	Funeral Director		5. Social Security Number $107-28-1798$ 6. Sex $1 \square$ M 2% F 90	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year) 1914	9. Birthplace (State of Country) New York	r Foreign	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Lc	cation				10d. Inside Cit	y Limits	
	Maryl s-f sho	tor	Maryland Anne Arundel		Riva				1 🗀 Yes	2 X No	
	3a or 28a	i Direc	10e. Street and Number 339 Brunswick Place		10f. Zip Code 2114	0	16	Og. Citizen of W	Vhal Country?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic event, the Medical Examine Lival by notified at ODGs.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ Yes Year or Dates:	ì	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- orto Rican, etc.)		e - American Indian, k, White, etc. : White		
Maryland 21215-0036	72 ho "natur	Completed by	15. Decedent's Education (Specify only highest grade completed)	6a. Decec	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of w	orking	16b. Kind of Bu	siness/Industry		
7	within iene. then	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		Bookkeepe:			Automo	tive		
g	al Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, M	faiden Sumam	е)		
Z Za	d Meni anarke marke	P	Walter Tryon Livingston TenBro		Address (Street a		e Newell :				
	nd 2 si alth an 27 is r		V. Ralph Lennon/son		-		Riva, MD	-	31a16, 21p C006)		
ore,	ages 1 a nt of Hea :: If item				sition (Name of natory or other place				City or Town, State		
Baltimore,	permit. P. Departme Important any injury		. 4 □ Donation 5 □ Other (Specify) Metro 21. Signature of Operal Service Licensee	-	matory, I		of Maryla		imore, MD		
	707 # 0		Dawn F. McDonald 23a. Part1. Enter the disease, or complications that caused the death.				d Baltime		Approximate		
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition and the state of t	AO					Interval Betwoonset and D		
	/Medical Examiner	<u>.</u>	Due to (or as a consequence of): Sequentially fist conditions from any, leading to immediate Due to (or as a consequence of):								
<u>.</u>	nd nd transit	Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events c. Chronic	Al	rial F	ibri	Hation		iyea		
ر 1760, ا	ate be executed nysician and he burial-transit	ical Ex	resulting in death) Last Due to (or as a consequent of the first of t	,.	Hy	pert	tensio	<i>/</i> U	1420	r.	
O. Box 68	Attending Physician: The law requires that the death certifica robath. robath. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery oth Day Y	ear	
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	ysician: The lavis certificate has director, page 2	omo					autopsy	pi egi? de	rior to completion of ca eath? □ Yes 2□ No		
/ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				eath (Check only one	2	Assis	ted	
of	Physi rrthis c sral dir): To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER. 27. Manner of Death 1 Manual 5 ☐ Pending (Month, Day Year) 28. Date of Injury (Month, Day Year)	Outpatien b. Time of	t 3 DOA Other	4 🗀 Nursing	Home 5 Resider		r (Specify) Livin		
ion	anding ath. or: Afte	ation	2 Accident investigation	Injury		? es 2 □ No		1.70			
Division of Vital	Hospital or Attending I 24 hours after death. Funeral Director: After tely tilled in by the funer	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Str. City or Town,		r or Rural Route Numb	99 <i>r</i> ,	
		edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	dge, death and/or inv	occurred at the time restigation, in my opi	e, date and place inion, death occ	ce, and due to the ca curred at the time, da	use(s) and man te and place, a	nner as stated. nd due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier Schutchinson MD		29c. License	number 0016	29	d. Date signed	(Month, Day, Year) Yil 24,20	005	
	B		30. Name and address of person who completed cause of death (Item 23 BARBARA HNTCHINSON 888	ia) (Type, I	Print) estaate	Rd	Sinte 21	5 An	ry 24,20 napelis	MA	
	Sta Registr	_	01 Day 51-1 44-11 Day V-11		1						
DH	MH 17 Rev 1/20		JAN 2 5 2005	1	sole						
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		-	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of t			g. No.	5 01680	
1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day Y	3. Time of Death		
+	Physicia /Medic	al	Lucille Mary Lop			T		TAN .	Day Year 12:30? M 4c. County of Death		
1	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death					
			7876 Golden Pine 5. Social Security Number 6. Se		e (In yrs. last birthday)	Sever	If Under 24 Hrs.	B. Date of Birth	Anne Arundel Birth 9. Birthplace (State or Fore		
	Funeral Director		218-05-9884	_м 2√Г г	84 Yrs.	Months Days	Hours Min.	une 22,	1920	MD MD	
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Mary -f sho	ţ	MD Anne A	rundel	Seven	rn				1 ☐ Yes 2 📉 No	
	n the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	
	th with	alD	7876 Golden Pine	Circle		211				U.S.A.	
21215-0036	be filed within 72 hours after death with the Maryland la! Hygiene. d other than "nature!, or items 23a or 28e-f show event, the Madral Exchiner must be mailfied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married ***Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American Indian, White, etc. White	
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of working		6b. Kind of Busi	ness/Industry	
21	within lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retired fice	d)		Retail	S2105	
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		1 01.	Lice	18. Mother's Name	(First, Middle, M		Dates	
Maryland		To Be	Charles Kriss				Eugenia	(UNKNO	WN)		
ary.	2 should be and Mental is marked (eumatic ev	Ĕ	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailii	ng Address (Street	and Number or Rural	Route Number,	City or Town, St	ate, Zip Code)	
	교육연극		Mrs. Michele Peter	son / dau	ghter 7876						
ore,	ges 1 an t of Heal if Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State		matory or other place			0c. Location - Ci	ity or Town, State	
Ĕ	Pages ment of ent: if it ury or o		*4 □ Donation 5 1 Other (Specify,	Entombmen	t Meadowrd:				Elkridg		
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Full and Strice Litens			2. Name and Addre	ss of Facility Sirvenue S.W.	_		Home P.A. MD 21061	
			23a. Part. Enter the disease, or comp	lications that caused	the death. Do not ent					Approximate Interval Between	
Į,	Pnysician		Seock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. SEVERE DEMENTIA								
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تِ	that i		Part II. Other significant conditions co	_	out not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	acco use contrib	ute to the cause of death?	
rds	quires n sigr	ed by	J)458 11 AGI	A				1 🗆 Yes	2 □ No 3	Probably 4 Unknown	
of Vital Records,	s bee	Completed						24a. Was an autopsy	24b. We	are autopsy findings available or to completion of cause of	
Re	The la	mo						perform	ed? de:	ath?]Yes a□No	
ital	sian: artifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Death				
γ	hysic this ce al dire	၉	1 Yes 2 No		ent 2 ER/Outpatie		1er: 4 ☐ Nursing Hom				
n c	ling P	ion;	27. Mann₃ of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary Year) 28b. Time of Injury	Wor	yat rk? Yes 2 □ No	8d. Describe hov	w injury occurred	,	
Division	death death ctor: , the f	licat	2 Accident investigation 3 Suicide 6 Could not be		jury - At home, farm, st			8f. Location (Stre	eet and Number	or Rural Route Number,	
Ω̈́	after Direction by	Certification;	4 Homicide	building, e	tc. (Specify)			City or Town,	State)		
	Hospite 24 hours Funerel stely filler	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysicien: To the best ninar: On the basis of and manner st	of my knowledge, deat of examination and/or in tated.	th occurred at the time to the time the time to the time the time to the time the time the time to the time the	me, date and place, a opinion, death occurre	nd due to the cau d at the time, dat	use(s) and manr te and place, an	ner as stated. d due to the cause(s)	
	To the Within To the	Me	29b. Signature and title of certifier	,		29c. Licens				(Month, Day, Year)	
			Money	n Mil	>	7)	57531	•	IAN 2	4,2005	
	10		30. Name and address of person who o	completed cause of	death (Item 23a) (Type,	, Print)	4		1. 1	2 21108	
	1		Mohit NES 31. Date filed (Month, Day, Year)	3601	rar's Signature	ins Mu	sy ruice	CERVIL	70- 100	-10	
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			JAN & J ZUU.	, Jacob	- /						

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			, .	and / Depa	artment of Health	and Ment	tal Hygie	ene 005	5 01681
	٥		Decedent's Name (First, Middle, Last)				ate of Death	Day Vo	3. Time of Death
	Physicia /Medid		ELEANOR R.	LAWS	SON		1	22 200!	5 1610 M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County of E	
			53 Nottingham Lane		Ocean Pi				ester
	Funeral Director		180-18-1001 1□M 2XF 84	rs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. D	ate of Birth Month, Day, Y C • 15 , 1	(ear) 920	Birthplace (State or Foreign Country) PA
	and **		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ecation				10d. Inside City Limits
	Aaryli Sho	ō		Ocean 1	Pines				1 ☐ Yes 2 X No
	28e-	ect	10e. Street and Number		10f. Zip Code		100	. Citizen of Wha	t Country?
	with Sa or	Funeral Director	53 Nottingham lane		21811			USA	,
	Jeath ms 2;	era	11 Marital Status 12. Was Decedent Ever in	1 U.S. 13.1	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify	Yes or No-	14. Race - A	American Indian,
0	after or Itel	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1			i, etc.)		Vhite, etc.
3	raf', c	by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No Specif	ry.		Specify:	White
ק	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural; or tems 23a or 28e-f show svent, I've Medical Evander must be codified at svent, I've Medical Evander or must be codified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16	b. Kind of Busin	ess/Industry
7	ithin ne. hen "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	1	*		CL		Maint Corn
V	led w tygier her ti		12 17. Father's Name (First, Middle, Last)		Co Owner	ther's Name (Firs			Maint. Corp.
5	be fi	Be				,		iden Sumame)	
Š	d Mer narke natic	ပို	Clarence Bingaman 19a. Informant's Name/Relationship (Type, Print)	10b Mailie	ng Address (Street and Num.	uth Your		ity or Tours Sta	te. Zin Code)
2	d 2 st th and 7 is n traun				Lower Forty				
_ ฆั	1 an Healt em 2		Michael J. Lawson Son 20a. Method of Disposition 20b		sition (Name of matory or other place)	Date	-	c. Location - City	
2	ages nt of t: If It		1		Cemetery	1/29/05	5	Baltimo	re. MD
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of the Iraumatic svent, It is Medical Exaction matter matter colling at once.		21. Signature/of Feneral Service Licensee		2. Name and Address of Fac				town Road
0	Dep Imp		I Stoham Jenken	- E.	line Funeral 1				MD 21136
			23a. Part1. Ent.: the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.						Approximate Interval Between
g.	Physician		Immediate Cause (Final	1	deat	Lenk) - M . a		Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a cons	sequence of:	many me	- eur	3011.002.		W Zeen
	Examiner		Sequentially list conditions		0				
-	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):					
	ecute and trans	Examiner	Cause (Disease or Injury that initiated events c	equation of):			-		
00,	ate be executed hysician and he burial-transit	cai E	Due to (of as a cons	iequentes on).					
-	physi the t		d						
X	ding ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pre-	gnancy				23d. Date of	delivery
	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
j.	the d ny the ached	Physician/Med	9 Unknown						
Ž.	The law requires that the death certifica ate has been signed by the atlending phage 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given in Parl	t I. 2	23e. Did toba	cco use contribut	e to the cause of death?
cords,	w require been sig should b						1 🗆 Yes	2□No 3□	Probably 4 Junknown
ာ သ	a 901	ompleted				2	24a. Was an autopsy	24b. Were	autopsy findings available
ř	siclan: The law certificate has irector, page 2 a	E O				1	performe	d2 deatl	to completion of cause of n? Yes 2 \sum No
		Be C	25. Was case referred to medical		26. Pla	ce of Death Che			
>	nysic nis ce I dire	2	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	P ER/Outpatien		Nursing Home	5 Residenc	e 6 Other (5	Specify)
5	ding Physiclan: h. After this certific funeral director,		27. Manne of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Work?		Describe how	injury occurred	
VISION	eath. or: A the fu	cati	2 Accident investigation		M 1 Tes 2				
Ë	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury · A building, etc. (Spe		reet, factory, office	28f. L	ocation (Stree Sity or Town, S	et and Number of State)	r Rural Route Number,
_	pitel urs a arel D		29a. Certifier 1 (2) Certifying Physicien: To the best of my	lunaviladas dasti	h and word at the time, date of	and alone and di	us to the sau	a(a) and mann	r on stated
	the Hospitel or Attending Physician: hin 24 hours attler death. The Funerel Directors After this certific pletely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physicien: To the best of my leads of the best of my leads of the best of	mation and/or in	vestigation, in my opinion, de	eath occurred at	the time, date	and place, and	due to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier		29c. License number	r	29d	Date signed (M	onth, Day, Year)
	- s - ō		Pales II (1 tom on		00050	6776		1/24	105
	1,		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print)				
	1		ROBERT L. CLINTON, MD	145 E	. CARROLL -	ST 5.4L	15BU	SV MO	21801
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Sig	gnature	este)				
	Registr	ar	THIN M O COURS !	15 State					

			Please '	Type or Prin State of Ma					-		egible.	0.1.0.0
			1 - State	State of Ivid	irytariu /	Certifica			ieman i	E (105	01682
	_		Registrar 1. Decedent's Name (First, Middle, Las	t)	•	001111100	210 07 2		2. Date of D			3. Time of Death
	Physici		DAIDH	1 4	TP	OW:	TT	7	Month A	Day		5/0:20A
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. C	ity, Town, or I	ocation of Death	(C- /- /- /-		unty of Death	
			MORTHWEST	- HOSPI	TAL	_		RANDALL	STOWN			BALTIMOR
	Funeral Director		214-16-1330	ox 7. Age IM 2□F	(In yrs. last b	Yrs. If Un Monti	der 1 Year ns Days	Hours Min.	8. Date of B	B, 1922	9. Birth Con	nplace (State or Foreig untry) MD
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location						10d. Inside City Limit
	Ba-f s	cto	MD N	1/A				BALTIMO	RE			1 X Yes 2 N
	or 28	Dire	10e. Street and Number			10f.	Zip Code			10g. Citizer	of What Co	
	ath w	rai	3330-A CLARKS LA					21215				USA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, II a Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🕱 Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:			cedent of His pecify Cuban 2 X No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	1	Race - Amer Black, White ecify:	
9	2 hou atura	ted	15. Decedent's Ed	ucation	168	a. Decedent's U	sual Occupat	ion		16b. Kind	of Business/I	ndustry
21215-0036	d within 7. giene. sr than "n	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5	+) ((Give kind of life. DO NO PTICIAL	Tuse retired)	iring most of work	ing	OPTIO	CAL	
Maryland	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) JACOB		1	_IBOWIT:	1	18. Mother's Nam FRIEDA	e (First, Middl	le, Maiden Su		IEDLANDER
ary	should land Men is marke	-	19a. Informant's Name/Relationship (7	ype, Print)				nd Number or Run				
	1 and 2 Health a em 27 is ther tra		STEVEN LIBOWITZ	/ SON	1	L0623 S	T. PAU	L AVENUE	- GRAI	NITE, N	1D 211	63
altimore,	00		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemete	of Disposition (in ery, crematory of GTON CH.	or other place	, MUNO 1/2	4/2005		ion - City or 1	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	500		22. Name	and Address	of Facility SO	L LEVII	NSON &	BROS.	•
}	Physician /Medical Examiner	niner	23a. Part. Enter ne diségée, or comp shock, or hyart failure. List only of Immediate Caule (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	EMA a consequence ORS	AL oot): ~ARY		- Cur	RE	arrest, EASE	_	Approximate Interval Between Onset and Death
68760,	ate be executed hysician and the burial-transit	icai Examiner	that initiated events resulting in death) Last	cDue to (or as a	a consequence	of):						
P.O. Box 6	The law requires that the death certificate beate has been signed by the attending physicial agge 2 should be detached for use as the burn	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the control	2 Fetal deat	h 3⊟Ectopie 5⊟Other	pregnancy (specify)			23d	Date of delik	very Day Year
	ires that the de signed by the a d be detached f		Part II. Other significant conditions of	ontributing to death bu	it not resulting	in the underlyin	g cause giver	n in Part I.		tobacco use		the cause of death?
of Vital Records,	e law requir has been si je 2 should l	Completed by							24a. Wa	s an 2	4b. Were aut	opsy findings available
Ä		Com							per 1 ☐ Yes	formed?	death?	
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of Deat	h (Check only			
Ž	Physician: this certific ral director,	일	1 ☐ Yes No	Hospital: Inpatie		utpatient 3		4 Nursing Ho	me 5 Res	sidence 6	Other (Spec	ify)
	ding J. After fune		27. Manner of Death Natural 5 Pending 2 Accident investigation		Year) 28b.	Time of Injury M	28c. Injury : Work? 1 🗆 Y	es 2 No	28d. Describe	how injury o	curred	
Division	Hospital or Attenv 14 hours after deat Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, f : (Specify)	arm, street, fac	tory, office			(Street and Nown, State)	umber or Rui	al Route Number,
	To the Hospital or Attenowithin 24 hours after deatl To the Funeral Director:	Medical (29a. Certifier (Check only one) Certifying Physical Example (Check only one)	vsician: To the best of iner: On the basis of and manner sta	examination a	ge, death occurr nd/or investigat	ed at the time ion, in my opi	e, date and place, nion, death occurr	and due to the red at the time	e cause(s) and , date and pla	manner as ce, and due	stated. to the cause(s)
	To the within 2. To the complet	W We	29b. Signature and title of certifier				29c. License	number		29d. Date si	gned (Month	, Day, Year)
•	15	1	186enne	170		9	Davi	9317		1/2	2/05	5

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person the complete BRES / 4FR / CR 31. Date filed (Month, Day, Year)

JAN 2 5 2005

No completed cause of death (Item 23a) (Type, Print)

NER 1838 FREENET REE RO

32 Registrar's Signature

2005

19RE MD 21208

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gregory Nelson Mills JAN 20 2005 9:40p/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab. Ct. Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) DISTRICT 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2 □ F Months Days Hours Min Director 579-03-1921 20, 1913 of Columbia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Crofton Maryland Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a Airy Court 21114 1611 Mt. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 NO 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2√ No Specify: Specify: White 3√∑ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Cabinet Maker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ٥ Jarrett King Mills Sarah Doughty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Gregory Mills/son Crofton, MD 21114 1611 Mt. Airy Court item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ± € 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Depintment of Important: If any injury or once. Metro Crematory, Inc. 01/22/05 Baltimore, MD nera Service Licensee Dawn F. McDonald 21. Signature of Funeral Se Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophag Pnysician od /Medical Due to (or a consequent notio Vanculandi saine Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ensi Due I Physician/Medical Examiner 10 tive Pulmonayou use as the burial transit Monic The law requires that the death certificate be exec Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital Yes the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 Tyes death. investigation hours after death unerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funerel D

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 14300 Gallant Fox Lane Suite 222 Bowie, MD 20715 Rakesh Arora MD 31. Date filed (Month, Day, Year) trar's Signature State 2005 Registrar

						artment of Health ar	· ·	_	
			1 - For State Ragistrar	State of Maryl		tificate of Death	reg.	/1115	01684
			Decedent's Name (First, Middle, La	st)		imouto of Bouth	2. Date of Death	NO.	3. Time of Death
1	Physici		Misu	Katherine	Moo	Co	JAN 2	3 2005	1:00 A. M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or Location of I		4c. County of Death	
H			Ivy Hall No	orsing Cent	ter	Middle Kiv	er	BALTIM	ORE
	Funeral		5. Social Security Number 6. S		(rs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. (Month, Day, Ye	ar) 9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		92 Yrs.		2-25-	12 W.	Virginia
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation			10d. Inside City Limits
	Many P-f sh	ţo	PA Voek		Ster	vartstown)		1 □ Yes 2 No
	th tha	lrec	10e. Street and Number (A .		10f. Zip Code		Citizen of What Cou	untry?
	hours after death with the Maryland turel', or items 23e or 28e-f show al Exemirer must be notified at	Funeral Director	3 Aspen	C J.		17363		USA	
	ar de	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		☐ Yes 2 No Specify:		Specify: / (hite
9	2 hou	ted	15. Decedent's E	ducation	16a. Deced	ent's Usual Occupation	16b	. Kind of Business/li	ndustry
215	within 72 ene. than "ne)	Completed	(Specify only highest gra	College (1-4or 5+)	Ι Λ	kind of work done during most of OO NOT use retired)	working	14 14	
7	filed with Hygiene. other than	Con	8		AS	sembler	F	actory	
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last,	4		18. Mother's	Name (First, Middle, Maid	len Sumame)	
Maryland 21215-0036	should be nd Mental s marked c	P_C	Michael Ju	Jay	40h Maita	- tay	nerine le). Ham	
Ma	Cl 40 - 60		19a. Informant's Name/Relationship (Booch	2 //s	g Address (Street and Number of	or Hural Houte Number, Cil	y or Town, State, 21	72/2
ē,	Health tam 27 other tr		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of natory or other place)	Date 20c	Location - City or T	Fown, State
OIII	Pages nent of int: if it		1 Burial 2 Cremation 3 □ 4 □ Donation 5 □ Other (Specif	THemoval from State	ardens c	n - 1 1 1	1-25-05 K	rsorlato	MO
Baltimore,	- 등 은 근		21. Signature of Funeral Service Lice	- Carte		. Name and Address of Facility	BALTIMORE	modia	
m	Depa impo any ir		Kimberly C	2. Salratry	EV:	ANS FUNERAL	CHAPFL 880	HARFORE	ORD.
г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.				•	Approximate Interval Between
	Pnysician	8	Immediate Cause (Final disease or condition	BREAS	T CA	NLEZ			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con:					
		_	Sequentially list conditions,	b. Due to (or as a cons	E S (
	ited Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	DENES	1-10				
ć	be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as a cons	sequence of):				
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89	The law requires that the death certifical tile has been signed by the attending phisage 2 should be detached for use as the	Physician/Med	IF FEMALE:	- , -		,			
Box	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy		23d. Date of deliv Month	very Day Year
	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5 □	Other (specify)			24,
P.0.	that the		Part II. Other significant conditions of	contributing to death but not	resulting in the ur	iderlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
Records,	uires signe	d by					1 ☐ Yes	2 No 3 Pro	bably 4 ZUnknown
00	w requir s been s should	Completed					24a. Was an	24b. Were aut	opsy findings available
Re	The lav	оше					autopsy performed 1 ☐ Yes 2 【	? prior to co	ompletion of cause of
Vital		BeC	25. Was case referred to medical			26. Place of	Death (Check only one)	40 12103	294110
of V	d: 5	To	examiner? 1 ☐ Yes 2 No		2 ☐ ER/Outpatien	3 DOA Other: 4 V Nursi	ng Home 5 Residence	6 □Other (Speci	ify)
n C	ing P	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	ijury occurred	
isio	Attanding or death. actor: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not b	e Oga Glass of Jaium A	It hama form etr	M 1 Tyes 2 No	28f. Location (Street	and Number or Pu	ral Pauta Number
Division	or A aftar Dirac Jin by	Certification:	4 ☐ Homicide determined	building, etc. (Sp.	ecify)	et, factory, office	City or Town, St	ate)	ar nobte Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	alc	29a. Certifier 1 Certifying Pt	nysician: To the best of my	knowledge, death	occurred at the time, date and p	lace, and due to the cause	(s) and manner as:	stated.
	the Ho nin 24 t the Fu npletely	edical	(Check only 2 Medical Examone)	miner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my opinion, death	occurred at the time, date a	and place, and due t	to the cause(s)
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License number	29d. I	Date signed (Month,	Day, Year)
	. ^		Savinda	14 Stelle	1110	D271	88 1	-24-	05
	1		30. Name and address of person who	completed cause of death (Item 23a) (Type, I	Print) A DI		1 .00	MJ 21222
			31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature CC 2	KET 114	ce Dun	CACCUL O	MI) 21222
	Sta Registr		JAN 2 5 200		K 1				
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				State of Maryland / Department of Health and M 1 - State Registrer Certificate of Death		iene 005	01685
				Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Time of Death
		Physici /Medic		Louise Gloria McGuire	Januar	y 23,200	
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dear	
				Gilcrest Hospice Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo	re hplace (State or Foreign
	ш	Funeral Director		577-20-8477 1 M 2 M F 83 Wonths Days Hours Min.	(Month, Day, 9-8-19	Year) Co	rginia
		P .		Usual Residence of Decedent	13-0-19	Z1 V1	
60		with the Marylar a or 28a-f show	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes No
2005		the M	Director	MD Baltimore Towson 10e. Street and Number 10f. Zip Code	14	Og. Citizen of What Co	
(=		With With		4102 Chardel Rd Unit 1G 21236		USA	ountry?
23		death ms 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Ame	
29	9	or Its	/Fu	1 Never Married 2 Married 1 Yes No Specify:	Hican, etc.)	Specify: Wh	
na	8	hours ural',	d by	3LXWidowed 4 □ Divorced Year or Dates:			
Jamasy	215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Itams 23a or 28a-f show ent, the Madical Examinat must be notified at	Completed	15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business	Industry
17	212	d with giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller		Financi	al
0	pu	al Hyg	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N	Aaiden Sumame)	
11 P	<u>ya</u>	12 should be filed within n and Mental Hygiene. 1s marked other then reumatic event, the M	Tof		Lula N		
MeGure	Maryland	s 1 and 2 should be filed within 72 hours after death w if Health and Mental Hygiene. Itam 27 is marked other then "natural", or Itams 23a other treumatic event, the Madical Examinationals.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		LEASE DESCRIPTION	
160	e,	permit. Pages 1 and 2 Department of Health a Importent: If Itam 27 ts any injury or other tree		20a Method of Disposition 20b Place of Disposition (Name of		e MD 21	
-	Baltimore,	ages ant of it: If It y or o				Parkvill	
RIA	i i	nit. Partme orten injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ZUUS		
GIORIA	Ã	Den time per		M01220 8800 Harford Rd.	Park	ville. M	d 21234
0				23a. Pan nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		and the second s	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition			Onset and Death Months
		/Medical Examiner		resulting in death) Due to (or as a consequence of .			
			<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
W		uted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease of night) that initiated events c.			
	o,	sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
	8760	cate be ohysicia the bur	dicai	d			
	9	ertific ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			
	Box	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No		23d. Date of del Month	ivery Day Year
	P.O.	the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown			
		The law requires that the death certific ate has been signed by the attending p cage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	ord	w require been sig	ted		1 X Ye	s 2 No 3 Pr	obably 4 Unknown
	ecc	law ri nas be	Completed		24a. Was ar autops	V prior to	itopsy findings available completion of cause of
	<u>=</u>	st cien: The lav certificate has rector, page 2	Con		perform	ned? death? No 1 ☐ Yes	2 No
	Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Ho			11
	of	Phys r this eral dii	T; To	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?	me 5 Reside	ince 6 COther (Spe w injury occurred	city) HOSPICE
	ion	nding F ath. r: After e funera	atior	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
	Division of Vital Records,	r Atte er de: recto	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti City or Town	reet and Number or Ru , State)	ural Route Number,
		itel or irs aft rel DI					
		To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated.	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
		within To the Comp	Ž	29b. Signature and title of certifier 29c. License number	-	9d. Date signed (Mont	
		(M. Hathany wy, und 0.25205		mory 2	5,2005
	_	12			to md	21204	
		Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 5 2005 32. Regular's Signature			

weie:	202	1 - For State Amend Items 2 Registrar 1. Decedent's Name (First, Middle, Last								2. Date of Dea		Year	3. Time of Death
nysici: Medic		Sara Mitchell								-	ryl4	, 2005	
xamin	er	4a. Facility Name (If not institution, give Salisbury Nursing			er	4b. City,		Location of		, Md.		County of Dea	
neral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. I		If Under Months	1 Year	If Under	24 Hrs.	8 Date of Birt	h	9 Rin	thplace (State or Forei
ctor		214-10-9027]M 2∏F	86	Yrs.	MOTITIS	Days	Hours	Min.	Nov 4,	1918	Ma	ountry) iryland
24.0		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		-					10d. Inside City Limit
0.00	tor	MD Wicomic	0		Sali	sbury							1 □ Yes 2X N
	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	ountry?
		200 civic Avenue						218				USA	
	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 Yes 2	?	S. 13. V	Vas Deced f Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14	4. Race - Ame Black, Whi	
	by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates		1	I□Yes 2	2⊠ No	Specify:			S	Specify: T	white
	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Deced	ient's Usua	l Occupa	ation	t of worki	na	16b. Kind	d of Business	Industry
	mple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life. L	kind of wor DO NOT us cler							
	e Co	17. Father's Name (First, Middle, Last)				ciei	real		r's Name	(First, Middle,			Maryland
	To Be	Harmon Smith								Marval			
	-	19a. Informant's Name/Relationship (7)	rpe, Print)		19b. Mailin	g Address	(Street a			I Route Numbe		Town, State,	Zip Code)
		Eddie Mitchell/	son					bara	Road	Orland	lo, F	L 328	08
.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F `4 □ Donation 5 ☒ Other (Specify)		e C6	ace of Dispo emetery, cren	sition (Narr natory or ot	ne of ther plac	е)	D	ate	20c. Loca	ation - City or	Town, State
OUCE.		21. Signature of Funeral Service Licens	Pleasant		St Ba	Name and atte	d Addres Anato ore,	of Facility Omy B MD	oard 2120	655 W.	Balt	imore	Street
al er	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Socientially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence s a consequenc	ence of):		cu	000				/	Onset and Death
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 🗌 Fetal	death 3	Ectopic pre	egnancy ecify)				23	d. Date of de Month	livery Day Year
	by	Part II. Other significant conditions co	ntributing to death	but not resu	lting in the ur	nderlying ca	ause give	en in Part I.					o the cause of death?
	Completed									24a. Was a autop perfor	sy	prior to death?	utopsy findings available completion of cause of
	Be	25. Was case referred to medical examiner?	Hospital:				Othe	15		(Check only or			
): To	1 Yes 2 No	28a. Date of In	jury	ER/Outpatien 28b. Time of		A Bc. Injury	4 1110		ne 5 🗌 Resid 28d. Describe h			ecify)
	atior	1 Natural 5 Pending 2 Accident investigation	(Month, E	lay Year)	Injury	М	Work	(? /es 2 □ l					
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of libuilding,	njury - At ho etc. (Specify	me, farm, stre	eet, factory.	, office		2	8f. Location (S City or Tow	treet and i n, State)	Number or Ru	ural Route Number,
	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes	of examinat	vledge, death ion and/or inv	occurred a	at the tim	e, date and pinion, deat	d place, a	and due to the dead at the time, o	ause(s) ar	nd manner as lace, and due	s stated. e to the cause(s)
	Me	29b. Signature and title of certifier				29c	. License	number		2	29d. Date :	signed (Mont	h, Day, Year)
		MANTE	20			6	72	95	49		4	410	
		30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type,	Print)			1				
		WILLIAM ROBINS, M.	- 000	CIVI						21804			

DHMH 17 Rev 1/2001

SARA MITCHELL

4346, 26,29 a

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN. **Physician** LORRAINE JOYCE CECILIA MORGAN 2005 2:40P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE 8. Date of Birth Feb. 13,1940 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 1 M 20XF 214-40-1931 64 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Medical Examinating must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21234 8304 Oakleigh Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 🏖 🐼 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist John Burnett,M.D. 12 yrs. N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter John Schmidt Cecilia Marie Kriss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter S. Cardiges (Husband) 8304 Oakleigh Rd. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 1-22-2005 Moreland Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home assaln 7401 Belair Rd. Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear CANCER -ung /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at id be detached fo 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injuly occurred Certification; After To the Hospitel or Attending 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours efter death To the Funerel Director: , completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 0 . Charles St. balto. md 21200 30. Name and address of person who convened cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar

				State of Mary				-	•	÷.
			1 - For State Registrer			rtificate of			2005	01688
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Ye	3. Time of Death
	/Medic		Norman	Lafayette	M	iley		January	19, 2005	
	Examin	er	4a. Facility Name (If not institution, given Buckingham's Cho		Care Ctr	4b. City, Town, o	or Location of Death		4c. County of D	
	Funeral				yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul 11,	Year) 9.	Birthplace (State or Foreign Country)
	Director		264-24-0668 Usual Residence of Decedent		31 Yrs.			Jul 11,	1923	Georgia
	arylan show	_	10a. State 10b. County Maryland Frede	1	c. City, Town or Lo Adams					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecto	10e. Street and Number	LICK	Audiis	10f. Zip Code		10	g. Citizen of What	
	h with	al Dir	3372 Upland Cour	t		217	1 0	10	U.S.A	•
	deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itama 23a or 28a-f show any njury or other traumatic evant. I've Medical Exactinar must be notified at ance.	Completed by Funeral Director	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 TYPes 2 □ No	1941 - 1974	1 ☐ Yes 2 🌠 No		nican, etc.)	Specify:	Vhite, etc. White
Ö	r2 hou	ted	15. Decedent's E	ducation		dent's Usual Occur	pation during most of working	11	6b. Kind of Busine	ess/Industry
215	ithin 7 ne.	nple	(Specify only highest gr Elementary/Secondary (0-12)	Coilege (1-4or 5+)	III e.	DO NOT use retire	(a)		US Coast	C
2	iled w Hygier her th	ပိ	17. Father's Name (First, Middle, Las.	4	Deput	Ly Comman	der/Atlan			Guard
anc	d be findal head of	Be c	Frank V		Miley		Lou	Ola	Thomps	On
Maryland	should nd Me mark matic	၉	19a, Informant's Name/Relationship			na Address (Street	and Number or Rura			
M	nd 2 saith ar 27 is 27 is ir trau		Mrs. Betty Miley				Court, Ada			
ore,	es 1 a of Hei f Item r othe		20a. Method of Disposition		Ob. Place of Dispo		. D		0c. Location - City	
ij	Pag ment ant: It		1 🛱 Burial 2 □ Cremation 3 ☐ `4 □ Donation 5 □ Other (Speci	fy)			Cemetery J			
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any njury or other traumatic event. It a Mapne.		23a. ParN. Enter the disease, or conshock, or heart faillifers. List only	nspe)	2:	2. Name and Addre Keenev &	ess of Facility Basford I	P.A. Fun	eral Hom	e
100	402 60		23a Park Enter the disease or con	visions that caused the	400706 1	106 East	Church St	Freder	ick, Mar	yland 21701
			shock, or heart failere. List only Immediate Cause (Final	one cause on each line.	-	ter trie mode or dyr	ng, such as cardiac o	respiratory arres	st,	
	Physician /Medical		disease or condition resulting in death)	a. End stage		Cancer				10 months
	Examiner		Supportable field over 19 cone	. Hyperter	ngion					Years
N.	po ii	iner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Du to (or as a co	nsequence of):					
ĵ.	te be executed ysician and le burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Hypother Due to (or as a co						Years
68760,	cate be ohysicia the bur			d. Parkinso	on's					Years
9 X	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy				23d. Date of	deliver
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	y 		Month	Day Year
	s that ned b a deta	y Pr	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying cause gi	ven in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
rds	en sig	ed b	Hypoalbumina; De	<u>ementia; Hiat</u>	al Herni	.a;		1 ☐ Yes	2 □ No 3 □	Probably 4 🖫 Unknown
Records,	law re as be 2 sho	Completed by	Irritable Bowel	Syndrome ; C	Cervical	Stenosis	•	24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
<u>=</u>		Соп	Gastroesophagel	Reflux Disea	ise			perform	ed? deatl	h? Yes 2□ No
Vital	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner?	Hannitali		Ot	26. Place of Death			
of	Phys r this ral dii	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 LI Inpatient	2 ER/Outpatie	of 28c Inju	rv at 2	ne 5 🗆 Resider 28d. Describe hov		Specify)
ion	Attanding r death. sctor: After by the fune	atlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) Injury	Wo	rk?]Yes 2□No		,,	
Division	il or Attandii after death. I Diractor: A d in by the fu	ertifica	3 Suicide 6 Could not 4 Homicide determined		At home, farm, st pecify)	reet, factory, office	2	28f. Location (Stre City or Town,		r Rural Route Number,
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Certification:	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the best of m miner: On the basis of exa and manner stated.	y knowledge, deal imination and/or in	th occurred at the tinvestigation, in my	ime, date and place, a opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	0.11	a	29c. Licen	se number	29	d. Date signed (M	lonth, Day, Year)
)	/) allen	. Neill	ejme	D54	749		January :	21, 2005
١	5		30. Name and address of person who J. Allen Reilly	completed cause of death	(IJem 23a) (Type,	Print) Se Avenue	. #D-1. Fr	rederick	. Marvla	nd 21701-6111
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature		<i>,</i> = , * *		, <u>,</u>	
	Regist		JAN 2 5 2	005	K A	marke 1				

		1- For Unpend Item 23a,27,28a-f per me 6840 Registrar Certifica	te or Death	2. Date of Death	j. No. 9 9 9	01002
hysicia	an	-		January	Pay 200 ^{Year}	3. Time of Death
/Medic Examine			r, Town, or Location of Death		4c. County of Death	
uneral rector		5. Social Security Number 191-42-6796 0. Sex 1	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y 7 – 15 – 54	(ear) 9. Birth Cou	place (State or Foreig intry)
Mow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limit
Ba-f s	Funeral Director	MD Baltimore				1X Yes 2 □ N
a or 2 be no	Dire		ip Code		g. Citizen of What Cou	intry?
ms 23	era	* '	21218 edent of Hispanic Origin? (Spe ecify Cuban, Mexican, Puerto		JSA 14. Race - Amer	
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No	ecify Cuban, Mexican, Puerto 2 Mo Specify:	Rican, etc.)	Black, White	
an "natu	Completed	Elementary/Secondary (U-12) College (1-4or 5+)	ual Occupation ork done during most of worki use retired)	ing 16	6b. Kind of Business/li	ndustry
ther than		12th Cook 17. Father's Name (First, Middle, Last)	18. Mother's Name		Restauran	nt
larked of	o Be	Norman Manuel		Blackwel		
is marked raumatic ev	ဥ		ss (Street and Number or Rura			ip Code)
tem 27 is other trau		Gregory Blackwell 7803 Mis	sty Ct. Gait	hersbur	g MD. 20	877
r oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Na cemetery, crematory or	ame of		Oc. Location - City or T	
lant: if Ite jury or o		`4 □Donation 5 □Other (Specify) Bayview Cre	ematory 1-19	1-05 Du	ındalk, M	ID
Important: if It any injury or one		21. Signature of Funeral Service Licensee 22. Name a	and Address of Facility Wes	ley Cha	avis Jr.	FH
sician ·		23a. Part 1. Enter the disease of complications that caused the death. Do not enter the moshock, or heart failure. Lift only one cause on each line. Immediate Cause (Final disease or condition				Approximate Interval Between Onset and Death
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Physician	1. Decedent's Name		Mauerhan,				2. Date of Dea Month January	th Day Yea	3. Time of Death 8:35 P M
/Medical Examiner	4a. Facility Name (If	not institution, give	street and number)			n, or Location of Deatl		4c. County of De	eath
Funeral Director	5. Social Security Nu 212-36-72	20 6. Se	e Medical ex Çxw 2□F	e (In yrs. last birt	TOWSON hday) If Under 1 Ye Months Da	ear If Under 24 Hrs.	8. Date of Birth (Month, Day Nov. 12	Baltimo (Year) 9.8 (,1940 Ma	re hirthplace (Stale or Foreign Country) aryland
death with the Maryland ms 23e or 28e-f show Livast be notified at neveral Director	Usuat Residence of 10a. State Maryland	10b. County N/A		10c. City, Town	or Location Baltimore				10d. Inside City Limits XIX Yes 2 ☐ No
Iter death with the Ma Items 23a or 28a-1 s Uner rount be notified Funeral Director	10e. Street and Num 4426 C	_{ber} 1ydesda1e	e Avenue		10f. Zip Coo	21211		log. Citizen of What	Country? USA
J36 urs after par, or ite	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent Armed Forces: 1XXYes 2 ☐ If Yes, Give Year or Dates:	No	13. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puerl No Specity:	pecify Yes or No- to Rican, etc.)		nerican Indian, hite, etc. White
21215-0036 ed within 72 hours af ygiener ygiener ti, the Medical Exam Completed by F	(Special Special Speci	15. Decedent's Ed fy only highest gra idary (0-12)		5+)		one during most of wor itired)	1	16b. Kind of Busines	
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Maryland nd 2 should be fite lith and Mental Hy 27 Is marked oth rtraumatic event To Be (19a. Informant's Na Barbara M	me/Relationship (dale Avenu	ural Route Numbe	r, City or Town, State	
Baltimore, M Jermit Pages 1 and 2 Department of Health Mportant: If item 27 I mportant: If item 27 I more.	20a. Method of Disp	osition	Removal from State	20b. Place of	Disposition (Name of	1	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	21. Signature of Fu				Burree	ddress of Facility -Henss-Sei alls Koad	tz Funer	al Home, i	Inc.
incate be executed incate be executed physician and physician and substitutions it is the burial-itransit edical Examiner	shock, or hear Immediate Cause (disease or condition resulting in death) Sequentially list con if any, leading to make a support of the cause (Disease or that indiated events resulting in death) L	trailure. List only Final inditions, mediate tying njury	a. BRADY (AA) Due to (or as b. HYPOTENS C. C.	ine. 2014 s a consequence	ot): A):	dying, such as cardiad		551,	Approximate Interval Between Onset and Death
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ding After fune			28a. Date of Inj (Month, D	ury 28b.	Time of 28c.	4 Nursing I Injury at Work? 1 Yes 2 No		lence 6 Other (S	pecify)
i patigna	3 🔲 Suicide 4 🗀 Homicide	6 Could not b determined	286. Place of it	njury - At home, fa tc. <i>(Specify)</i>	rm, street, factory, of	fice	28f. Location (S City or Tox		Rural Route Number,
In the Hospitel thin 24 hours a put the Funerel I mapletely filled	29a. Certifier (Check only one)			of examination an		ne time, date and place my opinion, death occ			
To the within 2 To the complete	29b. Signature and	title of certifier	d no		29c. Li	0547		29d. Date signed (<i>Mo</i>	onth, Day, Year)
b	30. Name and addr MICHAEL D.	0	completed cause of			5 POWSON, 1	no 21204	′	
State Registrar			32 Regis	trar's Signature		,			

Maverhan, Irvin M.

			For State Registrar	State of	Marylan		irtment of I <i>tificate of</i>	lealth and l	Mental Hy	giene 0	15	01691
			Decedent's Name (First, Middle, L.	ast)	-				2. Date of De	eath		3. Time of Death
	Physici /Medi		Nina F	R. Mauls	by				Janua Janua	ry 20, 2	Year 2005	10:30 A ^M
	Examir		4a. Facility Name (If not institution, g					or Location of Deat	h	4c. County		
			Greater Baltimor				Tows		0.0		Ltimo	
	Funeral Director		214-14-4646	Sex 7 1 ☐ M 2 💢 F	. Age (In yrs. 84		Months Days		(Month, D	3, 1920		place (State or Foreign ntry) yland
	land Dw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show must be notified at	호	MD Balti	more		Tows) T					1 ☐ Yes 2X No
	n the	Director	10e. Street and Number	more		10%30	10f. Zip Code			10g. Citizen of V	What Cour	ntry?
2	th with	ai D	6451 N. Charles	Street			212	212		US	SA	
2	r dea	Funerai	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puer	pecify Yes or No to Rican, etc.)			ean Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Inportent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ita Medical Examinal must be muitifud at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 Tes 2 If Yes, Give Year or Dat			☐ Yes 2X No		,		v: Whi	
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200	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Las	N/A		C1e	rk	18. Mother's Nar	ne /First Middle	Phone Maiden Suman		pany
	ld ba ental kad o	To Be	R. Contee Rose	7					na P.		.07	
Z.	should ind Men imarka umatic	F-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	t and Number or Ru			State, Zip	Code)
Ž	alth a		Saundra L. Mauls	by/Daugh	ter	2524	Ady Road	d Forest	Hill.	MD 21050)	
ore	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Demoval from St	20b. F	Place of Disposemetery, cren	sition (Name of natory or other pla	Jan.	Date	20c. Location -		own, State
Ĕ	Pag ment lent: I		'4 □ Donation 5 □ Other (Spec		"" Mt.	Comfo	rt	0 411 6	005,	Alexan	dra,	VA
\mathfrak{M}_{AUS} by Baltimore, Maryland 21215-003 \mathfrak{g}	permit. Departr Imports any Inji		21. Signature of Funeral Service Lic	9000		22	Name and Address	ess of Facility neral Hom	e of Du	lanev Va	11ev	Inc.
			23a. Part1. Exter the disease, or co	mplications that car	J. F.La	agle 10	W. Pado	neral Homonia Road	Timoni	um, MD 2	1093	Approximate
	Dharatatan	н	shock, or heart failure. List on Immediate Cause (Final	y one cause of ea	ch line.	mas di	or the mode of dyr	ing, soon as cardia	our rospitatory t			Interval Between Onset and Death
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ŏ	eath certifi attending for use as	2										
B	ne death the atte hed for	I S I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Estania programa			23d. Da	te of delive	эгу
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	Physici	an	1. Decedent's Name (First, Middle, La	Steven Sc	ott l	McCau1				2	2. Date of Dea	th Day	Year	3. Time of De	
	/Medic Examin		Steven Scott 4a. Facility Name (If not institution, given the control of the con						Location of		January		2005 ounty of Death	2:34 P /A	
	Funeral Director		5. Social Security Number 6. S			st birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. 8 Min. 0	B. Date of Birth (Month, Day 8/25/	Year) 1976		iplace (State or Finitry) MD	oreign
-	aryland show dat	_	Usual Residence of Decedent 10a. State 10b. County			Town or Lo								10d. Inside City L	
	th the Marylar or 28a-f ehow e natified at	Director	MD Anne A	runde1	M i 1	llers	vill 10f. Zip			-		10g. Citize	n of What Co	1 Tes 2	
	th wi		8151 Foxwell R	oad			21	108				U.	S.A.		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Madical Examinal mark he mailied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes	ify Cuba	n, Mexicar	gin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)		Race - Amer Black, White pecify: W		
21215-0036	nin 72 hou .n *natura Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	4)	16a. Deced (Give life. I	dent's Usua kind of woi DO NOT us	rk doné a	lurina mos	t of working	9	16b. Kind	of Business/I	ndustry	
21	d with	mo:	12	Conage (1 40/ 5	*,	Pa	inte	r				Subc	ontra	ctor	
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ry la	should ind Men marke umatic	P	Kenneth David 19a. Informant's Name/Relationship			10h Mailie	Address	(Stroot o			McCa			in Coda)	
Ma	id 2 si Ith an 27 is i		Trisha McCaule				-							MD 2110	าย
re,	s 1 and Heal		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nan	ne of	- 1	Da			tion - City or 1		,,,
E	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Spec		1		-			01/2	6/05	Ba1t	imore	, MD	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.		21. Signature of Funeral Service Lie	Sec							.Gonc			•	PA
	Physician	8 5	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused one cause on each ling Methadone	e.				-				а	Approximate Interval Betwee Onset and Dea	
1	/Medical Examiner		resulting in death)	Due to (or as							71				
	(E. C.)	niner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a conseque	ence of):									
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a conseque	ence of):									
687	ificate g phys	edic		0.											
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 [Ectopic pr Other (sp					23	d. Date of deli Month	very Day Yea	ar
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Vital	iclan: Th certificate ector, pag	Be (25. Was case referred to medical graminer?					117.		of Death (Check only or	18)			
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Division	To the Hospital or Attanding within 24 hours after death. To tha Funeral Director: After completely filled in by the fune	Certification;	2 Accident 3 Suicide 4 Homicide	1-21-04	iry - At hor c. (Specify)				-14	28	3f. Location (S City or Tow rene Dr	treet and in, State)	Vumber or Rui Oakwood en Buri	al Route Number I Road A nie, Md	nd
	ne Hospit n 24 hour na Funera sletely fille	edical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of the basis of and manner sta	of my know examinati	ledge, deat	h occurred vestigation	at the tim , in my of	ne, date ar pinion, dea	nd place, an	nd due to the c	ause(s) a	nd manner as	stated.	
	To the To the comp	Me	29b. Signature and title of certifier		10		290		e number		2	29d. Date	signed (Month	. Day, Year)	
			lakis	Mal /	Te			0	.C.M.	Ε.	J	anua:	ry 22,	2005	
			30. Name and address of person who	completed cause of d	4	111		Stre	et, I	Baltin	nore, M	aryl:	and 212	201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	5 2005		ure	Local	W							

			For State Registrar		State o	f Marylan		artment of I			ental Hy	giene	200	5	Ω	693
	a		Decedent's Name (First,	Middle, Las	st)			imouto or	2000		2. Date of De	ath			3. Time	of Death
М	Physici		Samuel	М		M	cClain				Month Januar	Day	, 200	ear 5	4.	45A ^M
	/Medic Examin		4a. Facility Name (If not ins				CCIGIII	4b. City, Town,	or Location		banaar		County of			4521
			Genesis Hea	lth C	are - S	everna	Park	Severna	Park			An	ne Ar	und	el	
	Funeral		5. Social Security Number	6. S	ex 1⊈M 2□F	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9	. Birthpl Count	ace (State try)	or Foreign
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	land ow		10a. State 10b. C			10c. Cit	y, Town or Lo	cation						10	0d. Inside	City Limits
	Many Feb	to	Maryland An	ne Ar	undel	Pa	sadena								1 🗌 Ye	s 2⊠No
	h the	Director	10e. Street and Number					10f. Zip Code		-		10g. Cit	izen of Wha	at Coun	try?	
	th wil	a	310 Delma Av	enue				2112	2			Unit	ed St	ate	S	
	r dea	Funeral	11. Marital Status		12. Was Deci	edent Ever in U proes?		Was Decedent of f Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spe	cify Yes or Ne	o-	14. Race - Black,	America White, e		
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덜	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or items 23a or 28a-1 show event, its Madical Examilization in the benchilited at	Be (17. Father's Name (First, M	iddle, Last,)				18. Moth	er's Name	(First, Middle	, Maiden	Sumame)			
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Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Rel				1	ng Address (Stree					-		'	
	Health Health tem 27		Milton McCla 20a. Method of Disposition	in -	SON	20b. F	-	elma Ave	enue		ate	_	Land ocation - Cit	211		
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 2000.		1 Eurial 2 ☐ Crem			1 /	cemetery, crer	natory or other pla en Memori	ice) Lal	Januai	ry 22					
Ħ	artme ortan injury		'4 □Donation 5 □ Ot 21. Signatur Funeral S			Par		. Name and Addr	ess of Facili	2005 lity		GLer	n Burr	nie, 2106:		yland
Ba	permi Depa Impo any ii		> Bui of	0	augh)		rkley-Ru I Crain			ral Ho	me E	.A. Burnie	, M	- aryla	and
			23a. Part1. Enter the disea shock, or heart failure	se, or com	plications that o	caused the deat									Approxima Interval Be	ate
	Physician		Immediate Cause (Final disease or condition	. List only		SCHEM	icc. (A/LDIO/	nyof	ATHY					Onset and	d Death
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	Examiner	_	Sequentially list conditions		b											
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Вох	eath certific attending p	M/us	IF FEMALE: 23b. Was decedent pregna			tcome of pregnation		Ectopic pregnanc	**/			1	23d. Date o		ry	
	ne deat the att hed for	sicie	in the past 12 months 1 ☐ Yes 2 ☐ No	?		nant at time of o		Other (specify)	·7				Month		Day	Year
P.0	that the de ed by the detached	Physician/Me	9 Unknown						landa Bad		an- Did	4=1====				
ds,	Se Le	i by	Part II. Other significant co	munions (contributing to a	eath but not res	suiting in the u	nderlying cause gi	ven in Part	1.			use contribu □No 31			r deat⊓? ∰Unknown
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Vital		e Co	25. Was case referred to n	adical					00 Di-		1 Yes	2 No	1 🗆	Yes	2 No	
5		O B	examiner? 1 ☐ Yes 2 ☑ No	- OGICEI	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Ot	hon		<i>(Check only</i> ne 5 ☐ Res		6 DOther	/Snacitu		
J Of	g Phys ter this neral di	n: T	27. Manner of Death		28a. Date		28b. Time of	28c. Inju			8d. Describe					
jo	Attending r death. ector: Atterby the fune	atlo	2 Accident	Pending nvestigatio	n	181, Day 1021)	injury		Yes 2	No						
Division	or Att	ertification;		Could not be determined	286. Place	e of Injury - At h ling, etc. <i>(Speci</i>	ome, fam, str fy)	eet, factory, office		2	8f. Location City or To	(Street an wn, State	nd Number (or Rural	Route Nu	ımber,
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer.	edical	29a. Certifier 1 Co (Check only one) 2 Mi	ortifying Pl odical Exa	miner: On the b	e best of my kno pasis of examina nner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	me, date a opinion, de	ind place, a ath occurre	and due to the ad at the time	cause(s) date and	and mann d place, and	er as sta due to	ated. the cause	e(s)
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	\$		30. Name and address of p	erson who	completed cau	se of death (Iter	m 23a) (Type,	Print)	W110	,-	0	- 1-14		1.7		-
1	V		BRIAN C.	WAC	CACE,	m), 9:	005 K	Print) (1 LB & 10)	c.Ro	AD, I	SALTIN	ORE	(hi)	21	1235	£
	Sta		31. Date filed (Month, Day	Year)	32. 8	Regionar's Sign	ature	1		7			/			
	Regist	ar	JA	N 4 9	2005	fall was	15	Grand								

				1- State of Maryland / Department of Health a Certificate of Death			2005	01694
		- · · ·		1. Decedent's Name (First, Middle, Last)	2. 🗆	ate of Death	Day Yea	3. Time of Death
		Physicia /Medic		Margaret A. Murison	Ja	anuary	23, 200	5 11:08 A ^M
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		4c. County of D	
		Funeral		Gilchrist Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24 Hrs. 8. D	ate of Birth Month, Day, Y		imore Birthplace (State or Foreign Country)
		Director		5. Social Security Number 2.12-30-5543A 6. Sex 1 Months 1	Min. Ja	in. 25,		Maryland
		show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		h the Marylar r 28a-f show	ctor	MD Baltimore Towson				1 ☐ Yes 2 💢 No
		vith the	Dire	10e. Street and Number 10f. Zip Code		10g	j. Citizen of What	Country?
		ns 23a	Funerai Director	601 Debaugh Avenue 21204 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig	gin? (Specify)	Yes or No-	USA 14. Race - A	merican Indian,
	9	after d	Fun	Armed Forces? If Yes, specify Cuban, Mexican, 1 Never Married 2 Married 1 Yes 2 Mo	, Puerto Ricar	n, etc.)	Black, W	hite, etc.
	Maryland 21215-0036	tiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther the Medical Examinar must be molffied at	d by	3 Wildowed 4 Divorced If Yes, Give Year or Dates:			Specify:	White
	15-	thin 72 he e. en "netu Wedical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working	16	6b. Kind of Busine	ss/Industry
	212	giene giene er tha	Com	Elementary/Secondary (0-12) College (1-4or 5+) 1 Office Manager			Denti	ist
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\	ıryla	12 should be filed within n and Mental Hygiene. r is marked other than raumatic event, the Me	ပ	Edward B. Ady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	rmelita er or Bural Boo			e. Zin Code)
10		9 = 2 -		John A. Murison, Sr./Husband 601 Debaugh Ave., T			21 204	5, <u>2,</u> 2 3 3 3 5,
0	Baltimore,	m O		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20	c. Location - City	or Town, State
53	tim			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	01/28/2		lomson, V	Maryland
0	Bal	permit. Departr Importe any inje		21. Signature of Funetal Service Utensee Stephen Coster 22. Name and Address of Facility Stephen Coster				L Home, Inc.
				23a. Part1. Ent * the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line.	cardiac or res	piratory arres	t,	Approximate Interval Between
to		Physician		Immediate Cause (Final disease or condition resulting in death) a. Cho(AngiocArcin	omA			Onset and Death Jean
B		/Medical Examiner		Due to (or as a consequence of).				Ü
6			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
00	N	ecuted and -transi	Examiner	Cause (Ulsease of Irijury that initiated events resulting in death) Last Due to (or as a consequence of):				-
É	760,	icate be executed physician and s the burial-transit	ai E	Dub to (of as a consequence of).				
3	687	rtificate ng phy as the	Aedicai					
	Вох	leath certifi attending I I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of Month	delivery Day Year
2	0	that the de ed by the a detached f	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown				
	٥,	ires that the signed by does detac	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did toba	cco use contribute	e to the cause of death?
	ords	v require been sig should b				1 🗆 Yes	2 000 3 🗆	Probably 4 □Unknown
	Division of Vital Records,	e iaw r has be	ompieted		:	24a. Was an autopsy performe	prior	autopsy findings available to completion of cause of
	talF	Physician: The lavithis certificate has al director, page 2	e Coi			I□Yes 2	XNo 1 Y	es 2□No
	f Vii	ysicia iis cert directe	To B	examiner?	of Death (Charsing Home		ce 6 X Other (S	ipecity) HOSDICE
	0 1	ding Phy h. After thi funeral o	on:	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at Work?	28d.		injury occurred	-
	isio	or Attendiates death. Director: A lin by the fu	ertificat	2 Accident Investigation M 1 Yes 2 N 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		ocation (Stre	et and Number or	Rural Route Number,
	Ď	s after	Certii	4 Homicide determined building, etc. (Specify)	2011	City or Town,	State)	Tibrar Toble Number,
		To the Hospitel or Attending Physician: The law requires that the death certificate be execul within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trader.	ledicai C		d place, and d	lue to the cau	se(s) and manner	as stated.
		thin 24	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number			d. Date signed (Mo	
		S T W			5		Smuin	423,200J
		7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	Cx x	2	423,2005
		l 		31. Date filed (Month, Day, Year) 32. Redistrar's Signature	cles	J. 7	DOLTO.	md 2(205
		Sta Regist		JAN 2 5 2005 32. Refistrar's Signature				

		•	For Stete Registrar	S	tate of	Marylan		artmen <i>rtificat</i>			ind M	ental Hy	giene Reg. No.	005	016	595
	Physici	an	1. Decedent's Name (First, Middi	e, Last)	7		_					2. Date of Dea Month	Day	Year	3. Time o	of Death
	/Medic		4a. Facility Name (If not institution	n cive stre		no oe		4h City	Town or	Location o	f Death	Jan	40.00	2005 unty of Deatl	h	<i>y +y</i>
	Examin	ner	a. I domy Hamo (if not institution					40. Oky,	10411, 01	COOLIGITO		nland	40. 00		 oward	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Birt	h ,		hplace (State untry)	or Foreign
	Director		176-54-4812	1 🗆 M	2/ Z VF	86	Yrs.	Months	Days	Hours	Min.	(Month, Da)		1		
þ	1940.		Usual Residence of Decedent			10- 0	. Taum and					July 2,	1910		Phillipine	
20	ehov d at	5	10a. State 10b. County			Toc. City	y, Town or Lo	ocation							10d. Inside (s 2 No
S et	28a-f	Director	Maryland 10e. Street and Number	Howar	d			10f. Zip		lighland		T	10a Citiza	n of What Co		74
÷ ×	a or							101. Zip	Code	207	77		rog. Onize	U.S	•	
death	"natural", or itams 23a or 28a-f ehow pical Examinar must be notified at	Funerai	13424 Allnutt Lane	12.	Was Deced	dent Ever in U.	S. 13.	Was Dece	tent of Hi			ecify Yes or No- Rican, etc.)	14.	Race - Ame	rican Indian,	
ָב קַּבָּ	in in in in in in in in in in in in in i	F	1 ☐ Never Married 2 Mar	ried	Armed Ford	2X No			11		, Puerto	Rican, etc.)		Black, White	e, etc.	
	le m	d by	3 Widowed 4 Divorced	i	If Yes, Give Year or Dat	tes:		1 Yes	Z/ZA, NO	Specify:			Sp	ecify:	Asian	
2 5	natu dical	Completed	15. Deceder (Specify only highe	nt's Educations of the Education	on Impleted)		(Give	dent's Usua kind of wo	rk done d	during most	of worki	ng	16b. Kind	of Business/I	Industry	
with in	han.	mpi	Elementary/Secondary (0-12)		College (1-	4or 5+)	lite.	DO NOT u		•				Bus	iness	
א ל	Hygie thar t int. II		17. Father's Name (First, Middle,	Last)					Busine	18. Mothe		(First, Middle,	Maiden Su	mame)		
5 4	c ava	o Be			illan								ncia Be	,		
at yidiild	f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic avent. Ite Madical	2	19a. Informant's Name/Relations	edro M ship <i>(Type,</i>			19b. Maili	ng Address	(Street a	and Numbe	r or Rura	I Route Numbe			Tip Code)	
i, IVIC	alth ar 27 Is ir trau	-	Mrs. Gloria Sunda	rocan	Dau	ahter	1	3424 A	lnutt L	ane Hid	hland	. Maryland	20777			
ָרָ בְּ	Department of Health ar Important: If item 27 Is any injury or other trau		20a. Method of Disposition			20b. P	Place of Disponentery, cre	osition (Nar	ne of			ate		tion - City or	Town, State	
	nent cantillant: If		1 Burial 2 Cremation 4 Donation 5 Other (5		ovai irom S	state	Columb	ia Mem	orial E	Dark	01/2	21/2005	C	larksville	, Marylan	ıd
	Departr Imports any inju		21. Signature of Funeral Service	Licensee	Pa.	Ma	293 2	2. Name ar	d Addres	s of Facilit	у					
a 8	79 = 29		Mullip	Ules	DU	QU!		S	lack F	uneral l	Home,	P.A.	City M	D-21043		-
			23a. Part1. Enter the disease of shock, or heart failure. List	r complicati t only one c	ons that ca ause on ea	used the deatl ich line.	h. Do not en	ter the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,	D 21043	Approxima Interval Be	tween
	hysician		disease or condition	a.	Lu	ng	Ca	ncer	_						Onset and	by (
	/Medical xaminer		resulting in death)		Due to (c	or as a conseq	uence of):								J	,
		-	Sequentially list conditions,	b	Due to (c	or as a conseq	uence of):									
t d	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<												
The law requires that the clean certificate he executed	hysician and the burial-transit	Еха	that initiated events resulting in death) Last	C.	Due to (d	r as a conseq	uence of):									
	ysicia ysicia	dicai		d												
	ng ph	Med	IF FEMALE:										1			
5	ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c.	1 Live bir	ome of pregna rth 2 ☐ Feta	Ideath 3[⊒Ectopic pi					230	 Date of deli Month 	ivery Day	Year
, 9	the al	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□Pregna 9□ Unknow	ant at time of di wn	eath 5[Other (sp	ecity)					WOITH	Day	i dai
r ted	od by detac		Part II. Other significant conditi	ons contrib	uting to dea	ath but not res	ulting in the u	ınderlying d	ausa niva	an in Part I		23e. Did to	bacco use	contribute to	the cause of	death?
נים ו	signe d be	dby	Humstens	5.1	Tolin.	F	Ple.	, ,	9	Fusion			es 2 🗆 l	_]Unknown
COLUS,	peen	ete	13/	· · / ·	8	72001		-				24a. Was	an (Ab More au	tongy findings	available
בי ק ק	s has	Completed										autop	med?	death?	topsy findings completion of	cause of
VII.di	ificate or, pa	e Co	25. Was case referred to medica	1						OF Place	of Dooth	1 ☐ Yes (Check only o	26 No	1 🗆 Yes	2□ No	
V eirie	s cert	0 8	examiner?	Hosp	oital: 1 □ In	patient 2	ER/Outpatie	nt 3 DC	Othe	200		ne 5 € Resid		Other (Spec	cify)	
5	er thi	n: T	27. Manner of Death	1		f Injury n, Day Year)	28b. Time o		8c. Injury Work			28d. Describe h		- ' '	y/	
OIVISION OF A Separation	ath. rr: Aft	Certification;	Z L Accident	igation	(NOTAL)	, Day Toar,	Injury	М		Yes 2 🗆 !	No					
	er de racto	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place o	of Injury - At ho g, etc. (Specif	ome, farm, st	reet, factor	, office		2	28f. Location (S City or Tox	Street and M	lumber or Ru	ral Route Nur	nber,
2 5	rs aft	Cer														
000	Fune Fune Fune	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physici Examiner	: On the ba	sis of examina	wledge, dea ition and/or in	th occurred rvestigation	at the tim , in my or	ne, date an pinion, dea	d place, a th occurre	and due to the o ed at the time, o	cause(s) an date and pl	d manner as ace, and due	stated. to the cause(s)
e de	within a hoper and are the death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	Med	29b. Signature and title of certific	95	and mann	ei StateG.		290	. License	number			29d. Date s	igned (Month	n, Day, Year)	
È	- 3 F 8		12		1		mi	01	741	120						-
	1		30. Name and address of person	who comp	leted cause	e of death (Iten	n 23a) (Type	Print)						V - /		
)		F Delean	107	724	little	Pete	Kent	F	Kwy		Colum	16.69	MI	210	144
	Sta		31. Date filed (Month, Day, Year		32. R	I'the Sistrar's Signa	ture	Angel.	,	0						
	Registi	rar	JAN 2	O 700	J	College of	10 p	1								

1/20/05

DISITACION MARQUEZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. I tem#19b, perFh, G839, 1/25/05 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician JANUARY 21, 2005 2:45 A MARRS ETHEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE JEWISH CONVALESCENT CENTER 8. Date of Birth (Month, Day, Year) MAY 4,1915 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Months Days **Funeral** Hours 1□ M 2 F ۷A 89 Yrs. 229-34-8652 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No BALTIMORE Director BALTIMORE 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21208 USA 7920 SCOTTS LEVEL ROAD by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ò Specify: WHITE 3 Widowed 4 Divorced Is marked other than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE FARMER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental ? HODD **MARRS** LAURA DOCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 2403 CROSS COUNTRY BOULEVARD - BALTIMORE, MD Health Item 27 | JUDY HARPER / GREAT NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State ₩ <u></u> 1 Burial 2 Cremation 3 R 0 permit. Page Department of Important: If any injury or once. BALTIMORE HEBREW CEM. 01/24/2005 BALTIMORE, MD Fyright Sery 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only the cause on each line. Approximate Interval Between Onset and Death alt1. Enter the disease shock, or heart failure. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a conseq ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 10 0

9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 277No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Medical Certification: To Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2€No hours after death.
Ineral Director: After this
y filled in by the funeral di 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Janua 21, 2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Reisteustraun 71136 Main 52 12915 32. Regiar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			State of Mary				•	•	Die.	0 1 4	0.7
		For State Registrar			rtificate of			Reg. No. U	U 5	016	9/
Physic		1. Decedent's Name (First, Middle, Las Mary P. Nastasi	•				2. Date of Dea Month January	Day	Year 05	3. Time of 5:00	Death DM
/Medi Examir		4a. Facility Name (If not institution, give Continuum Care of	street and number)		4b. City, Town, o	or Location of Death		4c. County	of Death	3.00	r
Funeral Director		Social Security Number 6. S		n yrs. last birthday)	-	If Under 24 Hrs.	8. Date of Birt (Month, Da Feb. 26	h Year)	9. Birthp	lace (State of try) / land	r Foreign
Maryland f show	jo	Usual Residence of Decedent 10a. State 10b. County MD Carroll		oc. City, Town or Lo					1	0d. Inside Cit	
with the last or 28e-	Director	10e. Street and Number 6570 Kali Drive		ider spar	10f. Zip Code			10g. Citizen of V	What Cour	itry?	
death v	erai	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	21784 Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert		USA 14. Rac	e - Americ	an Indian,	
036 burs after or rei', or liter Exercitive	by Fur	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🛣 No		o Rican, etc.)	Specify	ck, White,	etc. nite	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23s or 28e-f show any injury or other traumatic event, the Medical Eventher must be neithed at anse.	Completed by Funeral	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wor	king	16b. Kind of Bu		dustry	
ifiled w Hygier other th	Co	12 17. Father's Name (First, Middle, Last)		Homem	aker	18. Mother's Nar	ne (First, Middle,	Own Hom			_
rlan	To Be	unknown	Perki	nson	,	unknown	(, , , , , , , , , , , , , , , , , , ,		nner		
Mary and 2 shot alth and N 127 is ma		19a. Informant's Name/Relationship (1	Type, Print)			and Number or Ru		or, City or Town, MD 2178		Code)	
Baltimore, permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other ange.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To		
Iltin nit. Pa artmer ortent injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			1 Cy 1 CM Gal 2. Name and Addre	rdens 1/26	/05	Timoniu 1050			-
Bal permi Depa Impo any it		muchael	A Ruedy	R	uck Tows	n Funera		Towso		21204	1
Physician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	bleations that caused the cause on each line. a. Due to (or as a co	entra	ter the mode of dyi	ng, such as cardiad	or respiratory ar	rest,	4	Approximate Interval Betv Onset and D	veen
Examiner	ier	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co								
68760, filicate be executed gphysician and as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of);				·			
687 tificate tig phys as the			. d								
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 4 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Dai Mo	te of delive nth	,	'ear
ds, P.		Part II. Dther significant conditions o	ontributing to death but n	ot resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	obacco use cont		e cause of do	
Vital Records, siclen: The law requires tertificate has been signe rector, page 2 should be	Completed							rmed?	Were autoportion to condeath?	osy findings and pletion of ca	wailable tuse of
/ital	Be	25. Was case referred to medical examiner?					ath (Check only o		103	2010	
of Vita Physician: or this certific eral director,	n; To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	of 28c. Inju	ry at	ome 5 Resid	dence 6 Oth		′)	
Vision Attending r death. ector: After	catio	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ear) Injury	M 1	rk?]Yes 2□No					
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	4 Homicide determined	building, etc. (S	Specify)			City or Ton				oer,
Hosp 24 hou Fune eteky fil	edical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of miner: On the basis of exand manner stated	amination and/or in	h occurred at the tile tile tile tile tile tile tile til	me, date and place opinion, death occu	, and due to the or rred at the time,	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)	1
To the within 2 To the comple	Me	29b. Signature and title of ceptiles	÷ . /		29c. Licens	se number		29d. Date signed	d (Month, I	Day, Year)	
3		- Will	yu m	0	00	05813	7	1/24	15		
9		30. Name and address of person who	295 Stare	n (Item 23a) (Type, Are Si	Print) 4 307	Westmix	stor m	0 2/1	57		
St Regist	ate rar	31. Date filed (Month, Day Year) 5	2005 32. Registrar's	Signature	Sporte						

			For State Registrar	State of I	Maryland		artment of H tificate of I		d Mental H	lygien Reg. f	71115	01698
I	Physici		Decedent's Name (First, Middle, La	Helei	n Nort	h			2. Date of Month Janu	D	18, 2005	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, giv 3442 Elm Avenue	e street and numb	er)		4b. City, Town, or Baltin				4c. County of Death	
	Funeral Director		214-34-2746	Sex 1 □ M 2 X X 7.	Age (In yrs. las 94	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of (Month, April	Birth Day, Yea 20,	9. Birth Con 1910 Man	nplace (State or Foreign untry) cyland
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Man	ctor	Maryland N/	A			Baltimore	<u>:</u>				XXYes 2 □ No
	ath with th	ral Director	10e. Street and Number 3442 Elm Aven	ue			10f. Zip Code	21211		10g. C	Citizen of What Co	untry? USA
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event. Ite Medical Examinar must be motified at event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Nivorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ☑No	l l	Was Decedent of H fYes, specify Cuba 1 ☐ Yes 24☐XNo	ispanic Origin n, Mexican, Pe Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	within 72 ho lene. 'than "natur ine Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			(Give life. L	dent's Usual Occupi kind of work done of DO NOT use retired	during most of	working		Kind of Business/I	
d 21	filed w Hygier Ithar th	e Cor	unknown 17. Father's Name (First, Middle, Las.	1)			Cleaning	18. Mother's	Name (First, Mide		iaper Fac	tory
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Many	12 should h and Men 7 is marke raumatic		19a. Informant's Name/Relationship	**			g Address (Street a					
le,	s 1 and 2 should if Health and Mer Itam 27 is marke other traumatic		Raymond T. North, 20a. Method of Disposition	Jr. Di	other	ce of Dispo	ensington sition (Name of natory or other plac	1	Date	-	aryland Location · City or T	21116 Town, State
imo			1 ☐ Burial 2XXCremation 3 ☐ 1 ☐ Other (Special Control of Contr		118 _	timor	e-Washing	ton 1	/24/05		urel, Mar	_
Ball	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lice	expuli		B ₁	. Na <i>m</i> e and Addres urgee-Hen 631 Fa11s	ss of Facility ISS-Sei Road	tz Funer Baltimo	al Ho	ome, Inc. MD 21211	
	u		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one căuse on eac	h line.	Do not ente	er the mode of dyin					Approximate Interval Between Onset and Death
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Vital	Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	AEIEE	NOutpatien	Othe		Death (Check on)			
on of	ding After fune	\vdash	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		Bb. Time of Injury	28c. Injury Work				6 □Other (Speci jury occurred	ny)
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification:	3 Suicide 6 Could not to determined	28e. Place of	Injury - At home etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location City or	n (Street a Town, Sta	and Number or Rur tte)	al Route Number,
	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in	edicai	29a. Certifier (Check only one) Certifying P	hysician: To the be miner: On the basis and manner	s of examination	edge, death n and/or inv	occurred at the tim vestigation, in my op	ne, date and plantinion, death o	lace, and due to the	ne cause(le, date ar	(s) and manner as and place, and due to	stated. to the cause(s)
	To the vithing to the comp	W	29b. Signature and title of certifier	far r	NO		29c. License	3 2 2 C)	29d. D	Paje signed (Month,	Day, Year)
	X		30. Name and address 1 erson who	complete Jause of 3730 Fall	of death (Item 2)	3a) (Type, B			land 21	211		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2	32. Regi	strar's Signatur		Acast .	, ,	-			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** OKOronkwo videsa, 11:29 PM anuary 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medica If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 F MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Itama 23a or 28a-f ehow tre Medical Examinat must be collined at 1 Nes 2 No MORE Funeral Director 10e. Street and Number 10g. Citizen of What Country? FRANCONIA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mantal Hygiene. Important: If them 27 is marked other than "natural; or than 23a eny njury or other traumatic event, tha Medical Exaction at month once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: BIACH 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ORON TWO 19a. Informant's Name/Relationship (Type, Print) FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4406 FRANCONIA ST BAITEMA VICTOR OKORON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 1/25/2005 Woodlawn, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, 736 Edmondson Avenue; Catonsville, MD 21228 66 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner term Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mooths?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Tes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 140 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To after death. Director; After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 South Overle Street 32. Registrar's Signature Mighan Lynch 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Registra MEND ITEM #31 PER DVR G839 1935 105 tempf Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Ord 5 Norene S. 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Eldercare Salisbury Wicomico 8. Date of Birth (Month, Day, Year) 1915 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign VA Country) **Funeral** Months Days Hours 1 ☐ M 2 🕏 F 89 218-22-4731 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural; or items 23a or 28a-f show fraumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Wicomico MD Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 28360 Log Cabin Road 21801 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ white 3 ₩idowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if item 27 is marked other than ury or other traumatic event, I'me M 12 ACME Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alva Dickerson 2 Grover Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15363 Norman Road, Culpeper, Virginia 22701 Mr. Rodney Ord / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any njury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 1/25/2005 Glen Burnie, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 PRRL Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ean 1020 resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medical use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. Yes 2000 detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 8 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 2 No 1 Yes 1 Yes 20 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 ™ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident in by the Director 6 Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number a who completed cause of death (Item 23a) (Type, Print) 10 QUIC AVE. SALAS 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	1 - For State Registrer	State of Ma	-	artment of H		lental Hygien	1005	01701
Physician /Medical Examiner	Ernest	F. Pratt		4b. City, Town, or	Location of Death		y Year 005 :. County of Death	3. Time of Death 6:30a
Funeral Director	Renaissance 5. Social Security Number 567-05-0032		e (In yrs. last birthday) 90 Yrs.	Catonsv If Under 1 Year Months Days	rille If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year, OCT 21, 1	Baltii 9. Birth Cou 914 Wi	more place (State or Foreign intry) SCOnsin
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28e-1 show eumatic event, the Middeal Examinar must be multipled at To Be. Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. Cour Maryland Ba. 10e. Street and Number 709 Maiden 11. Marital Status 1 Never Married 2 M	timore Choice Lane 12. Was Decedent Armed Forces?	Ever in U.S. 13. \	onsville 10f. Zip Code Nas Decedent of Hif			itizen of What Cou USA 14. Race - Ameri Black, White	ican Indian, , etc.
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Baltimore, permit. Pages 1 ar Department of Hee Importent: If Item any Injury or othe once.	20a. Method of Disposition 1		20b. Place of Dispo cemetery, cren Metro Cre	ematory, Crematics	Inc. 1/24 horsociety	4/05 Ba y of Maryla		MD
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	/Medic	al	George Irvir 4a. Facility Name (If not institution				4b City Town o	or Location of Death	Januar		, 2005 County of Dea	10:30 A ^M
	Examin	er	1336 Mantel Str	-		ļ	Parkvill					e County
	Funeral		5. Social Security Number		ge (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth		thplace (State or Foreign ountry)
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36	p l		1 Never Married 2 Marri				I ∏ Yes 2 🔯 No		rican, etc.)	-	Black, Whi	White
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laryla 2 should	and f	1 3	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Street	and Number or Rui	al Route Numb	er, City o	Town, State,	Zip Code)
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Baltimore, Maryland 21215-0036	F Ite		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from State	i a	emetery, cren	sition (Name of natory or other place nera1_		Date	20c. Lo	cation - City or	r Town, State
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Red The	cate has cate has page 2 s	шо							auto perfe	ormed?	prior to death?	completion of cause of
Division of Vital Records,	certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Deal			1016	2010
of C	this certific	To	examiner? 1XXves 2 □ No	Hospital: 1 ☐ Inpati	ient 2 🗌	ER/Outpatien	t 3 DOA Ott	her: 4 🗌 Nursing Ho	ome 5 🗆 Resi	idence 6	S XOther (Spe	ecify) at scene
0 2	h. After th funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	A Wor	ry at	28d. Describe			
S O	death. ctor: A y the fu	cat	2 Accident investig	gation EOUN) 1-	21-05	10:20) M 1 🗆	Yes 2 No				NTHE STAMS
- ·	= 5 ± 6	Certification;	4 Homicide determ	ined 28e. Place of In building, e			eet, factory, office					ural Route Number, W
Hospital			29a. Certifier 1☐ Certifyin	g Physician: To the best		Muss does	annumed at the til	ino, data and place	1336 MA			EVILLE BALLOCO
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To the	within 24 h	Me	29b. Signature and title of certifie				29c. Licens	se number		29d. Date	e signed (Mon	th, Day, Year)
	~	_	> Would	5. The U	all	M	0.C.1	M.E.	J	anua:	ry 22,	2005
	6,		30. Name and address of person	who completed cause of			Print)					
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40	Sta		31. Date filed (Month, Day, Year)		trar's Signa	ture	\ \tag{\alpha}					
	Registr	ar	JAN 2 5 2	005 Million	1	()	State of the state					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Pe 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Victoria Louise Randolph anuaky 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. Pate of Birth (Month, Day, Feb 20, ys. last birthday . Age (In 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 3/□ F Maryland Director 212-26-8891 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28e-f shov the Medical Examinar must be notified at **Baltimore** 1 Yes 2 No **Funeral Director** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21217 624 North Monroe Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🔀 No 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Black Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Own Home College (1-4or 5+) Homemaker N8 marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Elizabeth Williams Richard Williams 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 09 624 North Monroe Street Baltimore, Maryland 21217 if item 27 Shirley Day 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o importent: if any injury or once. ö Catonsville, Maryland 01/27/05 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** 21. Signature of Figneral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home 1300 Eutaw Place Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: esn nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I the signed I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 1 Yes 2 1 1 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 28c. Injury at Work? Manyler of Death Time of Certification: 28b. 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 Yes 2 No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

egistrar JAN 2 5 2005

31. Date liled (Month, Day, Year)

32. Pegistrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

H Angell D

				1 - State of Mary	land / Depa <i>Cer</i>	artment of He tificate of D	ealth and Me Death	ntal Hygien		01704
		Physici /Medi			ice		2	. Date of Death	lay Yeer 18 200	3. Time of Death 5 9:50 PM
		Examir		4a. Facility Name (If not institution, give street and number) GOOD SAM ALITON KOSPITAL 5. Social Security Number 6. Sex / 7. Age (In	yrs. last birthday)	4b. City, Town, or I BALTIN If Under 1 Year	IORE		c. County of Dea	ith thplace (State or Foreign
		Funeral Director		219-66-6793 1 M 2 □ F Usual Residence of Decedent	47 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Year	7 mm	eyland
		vith the Marylan or 28a-f show be nutified at	ctor	10a. State 10b. County 10c	Baltiv					10d. Inside City Limits 1∰Yes 2 □ No
		th with the 23a or 28 181 be ru	al Director	3234 Barclay Street	et	10f. Zip Code	18	10g. C	Citizen of What Co	ountry?
	920	within 72 hours atter death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notitied at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Amed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	in U.S. 13. V	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 ☑ No	panic Origin? (Speci , Mexican, Puerto Ri Specity:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	
VIS	Maryland 21215-0036	d within 72 housens. Jiene. Ir then "neture In Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-4or 5+)	(Give i	OO NOT use retired)	uring most of working	16b. i	Kind of Business	,
REGINALA	and 21	77 75 14 14	To Be Col	17. Father's Name (First, Middle, Last)		ous DR	18. Mother's Name (i	First, Middle, Maide Bærre	n Surname)	
PEG	_	s t and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other treumette event,	Ĕ	19a. Informant's Name/Relationship (Type, Print) Sharon Rice (Wife)	19b. Mailin	g Address (Street ar	nd Number of Rural F	Route Number, City	or Town, State,	Zip Code) 1 d. 21218
CE	Baltimore,	2°= 5		20a. Method of Disposition 1 Denial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		sition (Name of natory or other place LEMORIAL	PK 1/2	5/05 WOO	Location - City or Od Lawn	, MD
J	Balt	permit. Pag Department Important: any injury o		21. Signatury of Funera) Service Licensee	M	Name and Address	tropolitar	N. BRM Chape	, ,	Beste, Md. Divis
•		Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the shock, or leart failure. First only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition)	DIAL I	or the mode of dying,		espiratory arrėst,		Approximate Interval Between Onset and Death
p	0,	ate be executed thysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the cause) Due to	•					
	68760	tificate be ng physicia as the bu	ledicai	d	4					
	Division of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year
	rds, P	quires that an signed b ruld be deta	ed by PI	Part II. Other significant conditions contributing to death but no ESRD (End Stage Rev	t resulting in the un	derlying cause giver	n in Part I.	23e. Did tobacco		o the cause of death?
	l Reco	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Complet	Congestine Heart Di	rease			24a. Was an autopsy performed?	24b. Were au prior to death?	utopsy findings available completion of cause of
	of Vita	hysician: this certific at director,	To Be		2 ER/Outpatient	3 DOA Other	4 Italising Home	5 Residence		cify)
	ision (ttending P death. ctor: After i	Certification;	27. Manner of Death 1			at 286 es 2 □No	d. Describe how inju		ural Route Number,
	Div	spital or A lours after neral Direc		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - building, etc. (St.) 29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the time	e, date and place, and	City or Town, Stat	te) s) and manner as	s stated.
		To the Ho within 24 h To the Fur	Medicai	(Check only one) 2 Medical Examiner: On the basis of examiner stated. 29b. Signature and title of certifier	nination and/or inv	estigation, in my opin	nion, death occurred	at the time, date an	nd place, and due	to the cause(s)
		n		Mo. Name and address of person who completed cause of death	(Item 23a) (Type, f	Print)	000			18,2005
		Sta	ate	TANIA LAMBA, MD 5. 31. Date filed (Month, Day, Year) 32. Registrar's S	601 LOCK	LAVEN	BLVD, BALT	imort,	MB 217	239.
	DH	Regist		JAN 2 5 2005 June 1	4 Good					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. - For Amend Item 1,25,27,28a-I per me 6839 1-28-05 tas Certificate of Death Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 5:25 PM Hilda N. Radding January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Center Prince Georges Cheverly 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2∑F Months Days Hours 119-24-5635 74 Director JUL 16, 1930 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ar than "natural", or items 23a or 28a-f show it a Medical Examiner must be notified at 1 X Yes 2 □ No Directo Prince Georges Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16010 Excalibur Road, Apt. D207 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status ould be filed within 72 hours after Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White ģ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If Item 27 is marked other than afty injury or other traumatic event, the Me Quita. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Nichols 2 Veda Weiland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20 Raymond Avenue San Anselmo, CA 94960 Jill Korst/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation = 5 ☐ Other (Specify) Metro Crematory, Inc. 1/21/05 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Society of MD, du Gregorchik 299 Frederick Road Baltimore, Edward A. MD 21228 23a. Part1. Enter the disea is, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine CENTRICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed burial-transit en that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4☐Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did acco use contribute to the cause of death? Yes 2 🗆 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1 ☐ Yes 213 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this neral Director: After the 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 3 Suicide 1-11-2005 5:15 \mathbf{A}^{M} 1 Yes 2 No Subject fell from bed Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
assisted living facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16010 Excalibur Rd. 4 T Homicide Mitchellville, MĎ within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Catevenis, M.D. 3001 Hospital Drive, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 5 Registrar It Aprelle

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician JAN Day 2005 Virginia Marie Rubin 19 11:50p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 316 Southway 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 088-20-0153 Director 92 10, 1912 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No **Funeral Director** Towson Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Virginia Avenue, Apt. 412 21286 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Restaurant Management Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Health and Mental I em 27 is marked o 2 Pierce Gladstone Gibbons Caroline Louise Duerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki M. Boulton/Daughter 316 Southway Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of It
Important: If ite
any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/21/05 Baltimore, MD Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 21. Signature of Funeral Service Licensee Edward AS & lwn 4 Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner therosclautic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.O. sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2□ No 1 🗌 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) daughter's examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ▼No Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide within 24 hours a 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed wuse of death (Item 23a) (Type, Print) 32. Regigrag's Signature OIE UNIV. PKWY BIN CHRISTOPHE 31. Date filed (Month, Day, Year) State 5 2005 Registrar

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1 - For State Registrer	State of Maryland / Department of Health and Certificate of Death		005 01707
Physician /Medical		2. Date of Death Nepth Day	3. Time of Death
	ution, give street and number) 4b. City, Town, or Location of Dea BALTI'M City 6. Sex 7. Age (In yrs. last birthday) 11 VM 2 F Yrs. 4b. City, Town, or Location of Dea BALTI'M City 1f Under 1 Year If Under 24 Hrs Months Days Hours Min	E. 8. Date of Birth	onty of Death 9/ Birthplace (State or Foreign Country)
Usual Residence of Decedent 10a. State 10b. Cou			10d. Inside City Limits 11√Yes 2 □ No
ath with the Market 123 or 283 straighted Market 123 or 283 straighted 10e. Street and Number 10e. Street and Numb	ulver St. 21229	L	of What Country?
o36 urs after death 11. Warital Status 1 Never Married 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Yes Give 1 Yes 2 Vin Specify:		lace - American Indian, lack, White, etc.
(Specify only his	D Dietary Assis	tant Gover	
Maryland A 2 should be file The and Mental Hy Th	Robinson Per	Ime (First, Middle, Maiden Sum Company Company City or Tow	1
20a. Meghod of Disposition	ion 3 Pemoval from State 20b. Place of Disposition (Name of Commetery, Crematory or other place)	St. Balto	n - City or Town, State
	In X: KUSS IZZZ W. North	Funeral Ho	me Md. 21216
shock/ or heart tature. Immediate Cause (Final disease or condition	e, or complications that caused the death. Do not enter the mode of dying, such as cardia List only one cause on each line.	c or respiratory arrest,	Approximate Interval Between Onset and Death
Examiner Sequentially list conditions	b. Due to (or as a consequence of): Due to (or as a consequence of): c. dabi mellitus		8 y aus
tree be executed by the property of the period of the peri	c. drabites mellitus Due to (or as a consequence of):		12 years
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Cords, P. Cords,	ditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
Vital Record Vital Record Sicien: The law require certificate has been signed. Sector, page 2 should be a special sector. Be Completed Completed Sector and sec		24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death? □ Yes 2 □ No
L special of the control of the cont	Hospital: V	ath (Check only one) Home 5 Residence 6 C	Other (Specify)
Lor Attending Physical Control of Attending Physical Control of Attending Physical Control of Attending Physical Office of Attending Control of Attending Co	28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how injury occ	
DIVISIO To the Hospital or Attendia Within 24 hours after death, To the Funeral Director: 8 Completely filled in by the fi Check only one) Salary Activities Activities Salary Activities Activities Salary Salary Activities Salary S	building, etc. (Specify)	28f. Location (Street and Nun City or Town, State)	
The Function of the Function o	ifying Physicien: To the best of my knowledge, death occurred at the time, date and place ical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	urred at the time, date and place	e, and due to the cause(s)
29b. Signature and title of cert	ntifier 29c. License number	29d. Date sign	ned (Month, Day, Year)
30. Name and address of pers	son who completed cause of death (Item 23a) (Type, Print)	AGNES HO	SP/12
State 31. Date filed (Month, Day, Ye Registrar	and manner stated. And Park Park Park Park Park Park Park Park	KACNF	MET IMAGE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 650 A M Royster January 20 2005 Deellear /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dinai Hospital of Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03 26 Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours Months 1 M 200 84 MDDirector 213-14-4119 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location death with the Maryland 10a. State 10b. County *ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examilier is ust be published at once. 1XYes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 U.S.A. 2823 Rona Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. atient Known as Royster 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes 21 No Black Baltimore, Maryland 21215-0036 Specify: Specify: þ X□XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm Supervisor 12tH grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EditH Moore Emmanuel Moraillis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2823 Rona Road, Baltimore, Md CHarlotte Wing-DaugHter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore Co, Md Woodlawn Cemetery 1/27/05 22. Name and Address of Facility
MarcH F/H West
4300 WabasH Ave, Baltimore, Md 21. Signature of Fundal Service License 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 WLLKS Apriration for free to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) attending physicien P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð pe 4 YUnknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed3 1 Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No м death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier NES 000 January 20,2005 alew ML yange and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Celián Valeno 32. Registrar's Signature State Registrar

ORIGINAL

		1 - For State Registrar			of Mar	yland / Dep <i>Ce</i>			lealth and Death			Reg. No	200	5 0	1709
Physic	ian	Decedent's Name (First, M	liddle, Las	1)						2.	Date of De Month	Da	ay Ye		me of Death
/Medi	cal	Lelia			0.		Ranso		t annies of Da		_1	20	2005 County of E		:30p
Exami	ner	4a. Facility Name (If not instited 3609 Delver			umber)		4b. Cit		Location of De	atn		40		eath	
Funeral		5. Social Security Number	6. Se		7. Age ('In yrs. last birthda			If Under 24 H		Date of Bi	rth	NA 9.	Birthplace (S	tate or Foreign
Director		217-22-4053	1 (□ M 2 🔭 F	89		Month	Days	Hours Mi	in.	(Month, Da	ay, Year -15)	Country) \	
P .		Usual Residence of Deceden													
arylar show	-	10a. State 10b. Coi	NA			loc. City, Town or I									de City Limits Yes 2 □ No
he M.	Director		IVA				timor					10.0			1163 2 110
with I		10e. Street and Number 3609 Delverr	5g c				101. 2	ip Code 21218	,				itizen of What	Country?	
death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral	11. Marital Status	1 1.0.	12. Was De	cedent Ev	er in U.S. 13	. Was Dec		ispanic Origin? In, Mexican, Pu	(Specify	v Yes or No		JSA 14. Race - A	kmerican India	an,
or Ita	by	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo		Armed F 1 Yes If Yes, C Year or	2 ∑ No Sive		If Yes, sp 1 ☐ Yes		Specify:	erto Ric	an, etc.)		0	White, etc.	
kin 72 hours sn "natural", Medical Ext	ted	15. Dece (Specify only hi	dent's Ed		n	16a. Dec	edent's Us	ual Occupa	ation during most of w	working		16b. l	Kind of Busine		
within 7 then the Med	Completed	Elementary/Secondary (0-	7		/ (1-4or 5+)	lite	DO NOT	use retired	()	vorking		•			
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\$ d a 5	Be	17. Father's Name (First, Mid	idie, Last)	_					18. Mother's N	Name (F	irst, Middle	, Maide	n Sumame)		
Z B Z E E	10	Walter 19a. Informant's Name/Relat	ionship (T	Bru	ce	Johnso		es (Street	Gert and Number or			or City		ison	
Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Virginia Lin			aught				te Ct.,					.040	
re, R s 1 and f Health item 27 other t	1 2	20a. Method of Disposition				20b. Place of Dis	osition (N	ame of		Date			ocation - City		ite
0 0		1 Surial 2 ☐ Cremat	ion 3 🗆 er <i>(Specif</i> y	Removal fror)	n State	King M			1	-26-	05	Do	ndalls	de car sec	F.24
Baitim permit. Pag Department Important: I		21. Signature of Funeral Sen	vice Licen	see					ss of Facility	20-		ltin	ore, M	d. 21	202
D Ped of Page of Stat		Ala	dup		an		Mar	ch F.	H. East		1101	Ε.	North		
		23a. Part1, Enter the diseas shock, or heart failure.	e, or comp List only	lications that	caused the	ne death. Do not e	nter the m	ode of dyin	g, such as card	liac or re	espiratory a	irrest,		Approx	al Between
Physician		Immediate Cause (Final disease or condition	882	a	Car	rdiova	SCU	lar	001	101	ose,			Unset	and Death
/Medical Examiner	Н	resulting in death)		Due to	o (or as a	consequence of):									
	_	Sequentially list conditions, if any, leading to immediate		b.	Moras a	consequence of):									
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	⊀	540 () (o. u.s u	oorisoquarico (ii).									
execu and al-tra	xar	that initiated events resulting in death) Last		c. Due te	o (or as a	consequence of):								-	
X 68 /60, certificate be executed ding physician and se as the burial-transit	call			d											
30 a £ £	- 5														
	Physician/Me	IF FEMALE: 23b. Was decedent pregnan	t	23c. If yes, o			□Ectopic	pregnancy				ļ	23d. Date of		
O. E he dea r the att	Sici	in the past 12 months? 1 □ Yes 2 1 □ No 9 □ Unknown		4☐Pre			Other (Month	Day	Year
ecords, P.O. BK law requires that the death as been signed by the atter 2 should be detached for u		Part II. Other significant cor	ditions of	notributing to	doath but	not reculting in the	undarhina	001100 0111	on in Part I	- 1	23a Did	tobacco	use contribut	a ta tha asua	a of doath?
dS, ires ti	l by	ratti. Other algilineant cor	iditions co	onthibuting to	ueatts put	not resulting in the	undenying	cause give	errin rediti.				2 □ No 3 □		
ecords, law requires (as been signe 2 should be	etec									-			1		<u> </u>
~ 0 - 0	Completed							**		-	24a. Whas auto perfe		24b. Were prior deatl	to completion	lings available to of cause of
		25. Was case referred to me	digal								1 ☐ Yes)
	o Be	examiner?		Hospital:	Innation	2 ER/Outpati	ent 3 🗆 (Othe	26. Place of D		1,100,000	30-5-0	6 □Other (S	Connectivity	
g Phy er this	-	27. Manner of Death		28a. Dat	e of Injury	28b. Time	of	28c. Injun Work					ny occurred	ор о спу)	
Attending I reath. ector: After by the funer	atlo	1 Natural 5 □ Pe 2 □ Accident in	ending vestigation		enth, Day 1	Yea <i>r)</i> Injury	М		K? Yes 2 □ No						
DIVISION at or Attending s after death. IN Director: After	Certification:		ould not be termined	289. Pla	ce of Injury ding, etc.	y - At home, farm, : (Specify)	street, facto	ory, office		28f.	Location City or To		und Number o. te)	r Rural Route	Number,
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Cert (Check only 2 Med one)	tifying Phi lical Exam	iner: On the	he best of basis of e	my knowledge, de examination and/or ed.	ath occurre	d at the tim on, in my op	ne, date and pla pinion, death oc	ace, and	I due to the at the time,	cause(s	s) and manne nd place, and	r as stated. due to the car	use(s)
To the comp	Ž	29b. Signature and title of ce	rtifier				2	9c. License	e number			29d. D	ate signed (M	onth, Day, Ye	ear)
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b		30. Name and address of pe		completed ca			9, Print)	N-	CALVE	ERI	- 57		BAL	TO, M	217.18
	ate	31. Date filed (Month, Day,)				s Signature									
Regist		JAN	125	2005	Elect	we to	1.5	E. A.							
DHMH 17 Rev 1/2	2001				,										

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hallie 4.05A M Vanciary 2005 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Good Samaritan N.H. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 257-36-5924 Yrs. Director 12-4-10 S.C 94 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow tra Medical Examiner must be notified at Yes 2□No Director NA Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21231 346 S. Ballou Ct. USA death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Mercy Hospital 6th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental 27 is marked of traumatic aver Jennings Esther Preston 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
important: If item 27 is
any injury or other trau 5535 Todd Ave., Baltimore, Md. Kenya D. Reid Granddaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 1-26-05 Baltimore, Md. ° 4 □Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 luin 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Hore Than Physician **ledical** Due to (or as a consequence of): ∟xaminer relevo Vas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 attending physicien Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 90 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed' certificate 1 Tyes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 4 Noursing Home 5 TResidence 6 Other (Specify) 1 🗀 Inpatient 2 ER/Outpatient 3FT DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number amaler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 Ballimole 21230 Kal 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 5 2005 Silven BigHAR State Registrar

			i icus	State of Maryland				_	_	
			1 - For State Registrar	Otate of Maryland		tificate of I			g. No. 2005	01711
			Decedent's Name (First, Middle, L.)	.ast)				2. Date of Death	1	3. Time of Death
	Physici /Medio		Isabel Franci	es Reiber				Month O /	Day Year	5 050 CAM
	Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		4c. County of Dea	th
			Good Samari			Balti			Baltin	
	Funeral Director			Sex 7. Age (In yrs. last	Vrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	_		578-36-4513 Usual Residence of Decedent					8-21-	30 Vic	gina
	ryland		10a. State 10b. County	10c. City, To	1					10d. Inside City Limits
	Be-1 s	cto	IND		BA	LTIMOR	25			1 Yes 2 No
	with th	by Funeral Director	10e. Street and Number	100 110		10f. Zip Code	220	10	g. Citizen of What Co	ountry?
	ns 23	erai	1232 Walt	12. Was Decedent Ever in U.S.	13 V		239 ispanic Origin? (Sn	ecity Ves or No.	14. Race - Ame	arican Indian
(0	ifter d	Fun	1 Never Married 2 Married	Armed Forces?	1		ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, Whit	
03	rel', o	i by	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give " Year or Dates:	1	☐ Yes 211 No	Specify:		Specify: W	hite.
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-1 show its Modical Exemirer must be notified at	Completed	15. Decedent's (Specify only highest of		6a. Deced (Give	ent's Usual Occupa	ation during most of work ()	ring 1	6b. Kind of Business	/Industry
121	within ene. then	m	Elementary/Secondary (0-12)	College (1-4or 5+)			-		at home	i.e.
	filed with Hygiene other the ent, the	Be Co	17. Father's Name (First, Middle, La	st)	NOR	emaker	18. Mother's Nam	e (First, Middle, M		٠
/lan	Mental Mental arked o	To B	Loslie Beac	h.			LOUIS	e Beac	h	
Maryland	should I and Ment is marked eumatic		19a. Informant's Name/Relationship	(Type, Print) 1	9b. Mailin	g Address (Street a			City or Town, State,	Zip Code)
	1 and Health em 27 ther tr		William H. Ki	eiber, DR.	232	uniker	c Hye, B	HLDMO.	RE MO	21234
JO.	Pages 1 nent of H nnt: If ite ury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from State	etery, crem	sition (Name of natory or other plac		Date 2	0c. Loc tion - City or	Town, State
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	THE	Moor	Name and Address	y 1-2	4-05 F	HEKVILL	= MO
Ba	permit. Departr Importe any inje		Kim la la	Zer Herter	FA 1	ALC -	TON OU		ON HARFUI	
			23a. Part1. Enter the disease, or co	mplications that caused the death. D by one cause on each line.	o not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	<i>JO [17444 O]</i> st,	Approximate
	Physician		tmmediate Cause (Final disease or condition	a. Ischemic C						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence		stagepati	9			
	Examiner	_	Sequentially list conditions, if any, leading to immediate	6. Hyperten						
	led	nine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to lot as a consequence	in all	20. 0				
, _,	al-trai	Examiner	that initiated events resulting in death) Last	c. Coronary Due to (or as a consequence	ce of):	ery Dis	slase			
1260	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cail		o Diabetes	ree	llitus				
89	ntifica ing ph a as th		IF FEMALE:							-
Вох	ath ce	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 🗌	Ectopic pregnancy			23d. Date of del	ivery Day Year
	that the death cer ed by the attendir detached for use	by Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 □	Other (specify)				July 104.
, P.O.	es that tigned by	y Ph	Part II. Other significant conditions	contributing to death but not resulting	g in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	w requires been sign should be	q pa		erebrovascular		iease.		1 ☐ Yes	2 No 3 ₽	obably 4 Unknown
000	ie law requ has been je 2 shoulk	Completed	(-	Remal Failur	2			24a. Was an autopsy		itopsy findings available completion of cause of
E E	The ate h	Com						perform	ed? death?	2 No
Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hamilal.		21		h (Check only one)	
of	g Physicien: ter this certifica neral director, p	1.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/	Outpatient		4 Nursing Ho	me 5 Resider	nce 6 Other (Spec	cify)
on	ding th: After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Year)	Injury	28c. Injury Work	(? Yes 2 □ No	200. Describe nov	v mjury occurred	
Division	or Attendii after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not determine	d 286. Place of injury - At nome,	, farm, stre	et, factory, office			et and Number or Ru	ıral Route Number,
	rs after or after bir bed in	Cert	TIOMINGS	building, etc. (Specify)				City or Town,	Siate)	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ht completely filled in by the funeral director, page	Medical	29a. Certifier 1 🔀 Certifying I (Check only one) 2 Medicel Ex-	Physicien: To the best of my knowled eminer: On the basis of examination	dge, death and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of artifier	and manner stated.		29c. License	number	29	d. Date signed (Monti	h, Day, Year)
	rs rö		Hon!	feltunt M	D	000	53671		01/17/20	-
-	h	1	30. Name and address of person wh	o completed cause of death (Item 23a	a) (Type, I			L		
-			Jon Tilburt	o completed cause of death (Item 23a M.D. 5415 Spc	- ()	ike Wai	1, Dal	nmore	1110 2	1212
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		1 9				
	negisti	aı	JAN 2 5	2005 1000	4	and the				

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		1 - For State Registrar	State of Marylan		artment of F			1	005	01712
		Registrar Decedent's Name (First, Middle, Last) ^		Timodio or	Douin	2. Date of Dea	th		3. Time of Death
Physici		K. Ann	,	52a	la.		JAN	Day 20	2005	10:20A.M
/Medic Examir		4a. Facility Name (If not institution, give		J 200		r Location of Death		4c. (County of Death	
LAdiiii	161	Pring Kings &	idae Rd.		PAR	KVILL	<u> </u>	B	ALTIM	ORE
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I	last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day			place (State or Foreign
Director		213-30-4204.	□M 200 F	2 Yrs.	Months Days	Hours Min.	4-13-	32		RYLAND
pu ,		Usual Residence of Decedent	100 6	, Town or L						0d. Inside City Limits
aryla shov	-	10a. State 10b. County	_	_					'	1 ☐ Yes 2, No
Ba-f	ectc		nort	PA	RKVILLI	<u> </u>		10- 011-		
with t	Ö	10e. Street and Number	2.1 21		10f. Zip Code	221		rog. Citiz	en of What Cour USA	•
death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	1702 hings A	1. Clare A.Cl. 12. Was Decedent Ever in U.	S 13	Was Decedent of H	lispanic Origin? (Si	pecify Yes or No-	1	4. Race - Americ	
ter d	'n	1 Never Married 2 Married	Armed Forces?	J. 10.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	Rican, etc.)		Black, White,	
urs al	b	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify: W	rite
Mithin 72 hours after ene. then "natural", or ite	Completed	15. Decedent's Edi (Specify only highest grad	ucation		dent's Usual Occup		kina	16b. Kin	d of Business/In	dustry
thin in	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	naig.	N	2	A Ca
A wi way yajen yajen ther the	Col	12		Jec	retary	/		10	ctors	Office
De file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,		,	
yla ould Men Men Men Men Marke	P L	JAMES CRA	19			Josep	hive		KWOWN)
Mar 12 sh 12 sh 12 m 13 m		19a. Informant's Name/Relationship (T	,	19b. Maili	ng Address (Street	0 1	ral Route Numbe	r, City or	Town, State, Zip	
e, n 1 and 1 and Health sm 27 ther t		John J. RUSZ 20a. Method of Disposition		lace of Disn	Osition (Name of	skidge	Date TA	20c. Loc	Alle IVI	1/2/234.
Or of the state of		1 Burial 2 □ Cremation 3 □	Removal from State	emetery, cre	matory or other place	(9)	11 -			. 2
Saltimo permit. Pages Department of Important: If i any injury or a		 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		arryVal		(das 1-0	7-05	lin	IONIUM	MID
Daltimore, Maryland ZIZID-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Extrahar must be notified at ance.		21. Signature of Funeral Service Licens	1/2 1 stand	1 2	z. Name and Addre	ss of Facility BA				
		23a, Part 1, Enter the disease, or comp	lications that caused the death	n. Do not en	ter the mode of dvir	EXTLCHA m. such as cardiac	PEL 8800		REDEDI	Approximate
		23a. Part1. Enter the disease, or comp shock, or heart failure. Lift only of Immediate Cause (Final	ne cause on each line.	11	+ /		Cont.			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence	Sal	C 4	114	6110	1		724/1
Examiner			Bue 10 (01 23 2 00113041		lis Der1	011/11/11				2116
	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):	1000	My ICI	- 3			244
ransit	Examiner	triat initiated events	С.		//					
O C	EX	resulting in death) Last	Due to (or as a consequ	uence of):						
icate be executed physician and sthe burial-transit	dical		d							
Ords, P.O. BOX 08/ requires that the death certificate een signed by the attending phys hould be detached for use as the	Med	IF FEMALE:								
DOX lath cer attendir for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	Ideath 3	Ectopic pregnancy	,		2:	3d. Date of delive Month	ery Day Year
he de	Physician/Me	1 ☐ Yes 2 ☐ No. 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 51	Other (specify)					
COIGS, P.O. BOX or vequires that the death certific been signed by the attending paround be detached for use as		Part II. Other significant conditions co	entributing to death but not resi	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to the	ne cause of death?
dS, uires sign	d by						1 □ Y	es 2	No 3□Prob	ably 4 Unknown
	lete						24a. Was a	30	24b. Were auto	psy findings available
VITAI HEC sician: The law certilicate has b irector, page 2 s	Completed						autop: perfor	sy med?	prior to co	mpletion of cause of
	C	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes th (Check only or	2 2 100	1 🗆 Yes	2 No
VIII rsicia s cert	0 B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	or	ome 5 X Resid		Other (Specif	v)
Phy g Phy er this	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe h			,,
ndin ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Motter, Day 16at)	Injury		Yes 2 □ No				
JIVISION for Attending after death. Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
Ital or rail Dil	Cer									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina	wledge, dea ion and/or i	th occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the o	ause(s) a date and l	and manner as s place, and due to	tated. the cause(s)
thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. licens	e number	2	29d. Date	signed (Month,	Dav. Year)
F 3 F 8			. 41	1/	1)/	,77	2/	1-	-71	16
D		30. Name and address of person who o	ompleted cause of death (Item	(23a) (Type	Print)	14)		<u></u> /	
\.\!\		St. Hallo and godious of person who c	7	601	Osto	MY	ilic		104 Gm	21204
Sta	ate	31. Date filed (Month, Day, Year)	32. Reg rat's Signa	ture	0	101			- W	1 clay
Regist	rar	7 THE W. D.	2005	A -	-					

			. For	State of Ma	ryland / Depa	artment of H	lealth and Menta	•	9	01713
			1 - Stete Registrar		Cei	rtificate of	Death	Reg. N	lo.	01710
	Physici /Medio		1. Decedent's Name (First, Middle, La	W. Bink	ie Jr.		2. Dat Mo	e of Death nth D	y Yeer	- 1 / 1 / 1 / 1 · 1
	Examir		4a. Facility Name (If not institution, give Mariner Healt	001	Burnie	4b. City, Town, o	Burnie	4	c. County of Dec	ath
	Funeral Director		5. Social Security Number 6. 5		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Dat	e of Birth opth, Day, Year	r) C	nthplace (State or Foreign Country) ryland
			Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation		1-031	731 114.	10d. Inside City Limits
:	B Marylisa-f sho	ctor	-11-0-	/A		imore				1 Yes 2 No
:	With th	I Director	10e. Street and Number 1403 Webster S	treet		10f. Zip Code	1230	10g. C	Citizen of What C	-
980	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23e or 28e-f show that the Medical Examinat must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Specify Yean, Mexican, Puerto Rican, Specify:	es or No- etc.)	14. Race - Am Black, Wh Specify:	
15-0	"neturel", or	ieted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup	pation during most of working d)	16b.	Kind of Business	s/Industry
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hr It of Health and Mental Hygiene. If item 27 le marked other than "neu or other traumatic event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		rinter		Am	erican]	Lithograph
PL S	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last				18. Mother's Name (First,	Middle, Maide		_
<u> </u>	2 should be and Mental le marked o aumatic eve	٩	Henry W. Rin		10h Maili	on Address /Compt	Nep1 and Number or Rural Route	Atombo o Otto		lusa
Ma	1 and 2 si Health an em 27 le r ither traur		Mary L. Rinkle	(Wife)			r Street, Bal			
ore,	permit. Pages 1 and Depertment of Health Important: If item 27 any injury or other tr 2005s.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Dispo cemetery, cres	esition (Name of matory or other pla	Date	20c. l	Location - City o	r Town, State
Ei m	Pa ant ury		* 4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service-Lice		Cedar Hil	I Cemete: 2. Name and Addre	-	Bro	oklyn Pa	ark,Maryland
Ba	Deprit Deprit Importu any inj		Tun Ole	comul		Cully-P	lyniak Funer Fort Avenue,	al Home Baltime	e P.A. ore. Mai	ryland 21230
V.09	e be executed / Medical Medical porumers porumers in a porumer in a po	cai Examiner	and an analysis and a second a second and cond and cond and a second and a second and a second and a second a	Due to (or as a	consequence of):	er the mode of dyin	IN FAR	atory arrest,	ASE	Approximate Interval Between Onset and Pearly
P.O. Box 687	Attending Physicien: The law requires that the death certificate is refeath. ector: After this certificate has been signed by the attending physis by the tuneral director, page 2 should be detached for use as the by the tuneral director.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnanc Other (specify)	,		23d. Date of de Month	elivery Day Year
ds, P	uires that signed b d be deta		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I. 23	. /		o the cause of death?
CO	w requir s been si should	olete	CHPANIC F	+LCOHOL	LSM		24	a. Was an	24b. Were a	utopsy findings available
of Vital Records,	icien: The lav certificate has rector, page 2.3	Completed by		, 10				autopsy performed? Yes 2 N	/ death?	completion of cause of s 2 No
<u> </u>	eicier certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Yo	Hospital:	t 2 ER/Outpatier	ott pos Ott	26. Place of Death (Chec		A = 0.15	w.,
on of	ding Phye h. After this funeral di	tlon; To	27. M nn of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur	er: 4 ursing Home 5 y at 28d. De k? Yes 2 □ No	escribe how inju		ecity)
Division	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not to determine determined	OB Place of tojus	y - At home, farm, str (Specify)		28f. Loo	cation (Street a y or Town, Stai	and Number or Fi te)	Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely fitted in I	Medical C	29a. Certifier (Check only one)	hysician: To the best of miner: On the basis of and manner state	examination and/or in	h occurred at the til vestigation, in my o	me, date and place, and due pinion, death occurred at th	to the cause(e time, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	lingh	. A.	29c. Licens	e number 14160	29d. Da	ate signed (Mon	th, Day, Year) 23, 2005
	4/1		30 Name and Oddress pt person who	completed cause of dea	ath Morn 23a) (Type,	2010-	A RITCHI	EHU	GHIVE	972
	Sta	ate	31. Date filed (Month, Pay, Year) JAN 25	32. Raistrar	's Signature	_13A	TIMORE	MAF	YLAN	0 2123

			Please T	ype or Print	in Black	Indelible Ink	. Ensure A	II Copies	Are Legible.	
			_ For	State of Mar	yland / D	epartment of	Health and N	lental Hyg	gierne	01711
			1 - State Registrar		(Certificate of	Death	F	Reg. No.	01114
			1. Decedent's Name (First, Middle, Last)			[4]		2. Date of Dea		3. Time of Death
	Physici /Modi:		Delma			Reynolds		Janua!	Day Year	
	/Medid Examir		4a. Facility Name (If not institution, give s	treet and number)			or Location of Death	47,10	4c. County of Dea	
П			North Arunda	el Hospi	tal	6len	Burnie		Anne	arunde/
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birtl	h year) 9. Bi	rthplace (State or Foreign country)
	Director		402-40-7664	M 2 🗷 F	73 Y	rs.	1100	(Month, Day Aug. 20	, 1931 Ke	ntúcky
	pur *		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	sho	ō	Maryland Anne Aru		Pasade					1 ☐ Yes 2 ☑ No
	28e-1	Directo	10e. Street and Number	inder	i asade.	10f. Zip Code			10a Citizan of Minas C	
	a or	ō							10g. Citizen of What C	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show ont, the Mudical Examilinar must be redified at	Funeral	58 Lakeshore Drive	2. Was Decedent Eve	ar in IIS	2112:		ecity Yes or No-	U.S.	
40	iter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	31 111 0.0.	 Was Decedent of If Yes, specify Cub 	oan, Mexican, Puerto	Rican, etc.)	Black, Wh	
980	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	Mhite
21215-0036	2 hou	ted	15. Decedent's Educ		16a. [Decedent's Usual Occu	pation		16b. Kind of Busines:	
21,5	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done life. DO NOT use retire	adring most of work ad)	ing		
	giene giene er th	TO.	9	N/A		Housewi	fe		Own H	lome
p	al Hy al Hy I oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
la	Ment Ment arkec	70	Wardie		Sta	сеу	Minnie			Rudd
Maryland	2 shc and Is m		19a. Informant's Name/Relationship (Type	oe, Print)	19b. I	Mailing Address (Stree	t and Number or Run	al Route Numbe	r, City or Town, State,	Zip Code)
	and ealth m 27	l s	Marvin L. Reynolds						Maryland 2	
ore	of H of H if Ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		20b. Place of C	Disposition (Name of crematory or other pla	ice)	Date	20c. Location - City o	r Town, State
Ē	Pag ment ent: ury c		`4 ☐ Donation 5 ☐ Other (Specify)		Glen Ha	aven Mem. 1				e. Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at ance.		21. Signature of Funeral Service License	0		MCCully-Po	ess of Facility Olyniak Fu	neral H	ome. P.A.	
_	<u>a</u> 05 a a		John F	Colline		3204 Mount	tain Road	Pasaden	a, Marylan	d 21122
П			23a. Part1 Enter the disease, or complications shock, or heart failure. List only on	e cause on each line.			_		_	Approximate Interval Between
E .	Physician		Immediate Cause (Final disease or condition	Chroni	c 06st	ructive	Pulmene 1)is=0.50 ((Emphysema)	Onset and Death UCOYS
	/Medical Examiner		resulting in death)	Due to (or as a o	onsequence of):	2		• 0	,
п	Examiner	_	Sequentially list conditions, if any, leading to immediate	D						
ス	be tis	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of	} :				
1	be executed ician and burial-transit	xan	that initiated events cresulting in death) Last	Due to (or as a c	onsequence of).				
60,	be executed sician and burial-transit	a E		200.0 (0. 00 0		<i>,.</i>				
687	death certificate I attending physicaters of the terms of	Gic	d							
×	death certificate e attending phys d for use as the	/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy				23d. Date of de	livon
Вох	atter for L	clar	in the past 12 months?	1 ☐ Live birth 2 (4 ☐ Pregnant at tin	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		Month Month	Day Year
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<u>α</u>	The law requires that the death ste has been signed by the atte bage 2 should be detached for	by Physician/Medic	Part II. Other significant conditions con	tributing to death but i	not resulting in t	he underlying cause g	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Vital Records,	uires n sign		Lung Can	cer				1 🗗 🕈	es 2 No 3 P	robably 4 Unknown
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Re	he la e has age 2	Completed		1	1 10.1	, 1	+ d see	autop: perfor	med? prior to death?	completion of cause of
lal		e C	25. Was case referred to medical	rter an	x vay v	var hea	26. Place of Deat		2 No 1 Yes	s 2 No
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ð			27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 28c. Inju			ow injury occurred	eny)
ion	nding th. T: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Inj		Yes 2 No			
Division	Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, fam	n, street, factory, office			treet and Number or R	ural Route Number,
	s afte	Cert	4 Tromode	building, etc. (<i>Зреспу)</i>			City or Tow	n, State)	
	ospit hour unere iy fille		29a. Certifier 1 Certifying Phys	ician: To the best of r	ny knowledge,	death occurred at the t	ime, date and place,	and due to the c	ause(s) and manner a	s stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	one) 2 Medical Examin	er: On the basis of ex and manner state	d.	or investigation, in my	opinion, death occur	ed at the time, o	late and place, and du	e to the cause(s)
	To t	Σ	29b. Signature and title of certifier	110		29c. Licen	se number	2	29d. Date signed (Mon	th, Day, Year)
•			1 / holes	luces	m m	O O	94987		JANUARY	21,200)
	. 0		30. Name and address of person who co	npleted cause of deal	th (Item 23a) (T	ype, Print) Ch	welas E. L	V .1=8 =	III MD	,
	10		North Aruna		pita	C G	len	Burn	ie h	CY
	Sta	á	31. Date filed (Month, Day, Year) JAN 2 5 201	32. Propistrar's						
	Registi	di	OHIV N O 200	13 Bolove	, K	Shoull o				

		1	For State Registrar		St	ate of	Marylar	nd / Dep <i>Ce</i>	artmer ertifica:	nt of H te of L	ealth a	and M	lental Hy	gien Reg. N		15	01715	
Div			Decedent's Name (First, Middle, Last)							2. Date of Month				ath Da	av	Year	3. Time of Death	
	Physicia /Medic Examin	al	Alice Marie Rilling										Janua	ry	17, 2	2005	5:56 pm ^M	
Ex		er	4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death				4c. County of Death				
Eur	oral		Holy Cr 5. Social Security N		spita 6. Sex	1	7. Age (In yrs.	last birthday	If Unde	r 1 Year		24 Hrs.	8. Date of Bi	th		lont g	Omery lace (State or Foreign itry)	
	irector The 23a or 28a-1 show at must be notified at a must be notified at a must be notified at a must be notified at a must be notified at a must be not					C++ +C			s. Months Days Hours			Min. (Month, Da)				consin		
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the h		Director	10e. Street and Nur		gomer.	у		STIVE		10f. Zip Code					itizen of	What Coun	try?	
h with			428 Northwest Drive						20901					Į	United States			
deat		Funerai	11. Marital Status 12. Was Dece Armed For					J.S. 13.	Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,				cify Yes or No Rican, etc.)		an Indian, etc.			
illed within 72 hours atter death with the Maryland Hygiene. Hygiene.	qua	by Fu	l If Y			☐ Yes Yes, Giv	⊒Yes 2 TNo Yes, Give ear or Dates:			1 ☐ Yes 2 ☐XNo Specify:				Specify: white				
hour	n "netural" Medical Ex		15. Decedent's Education				1185.	16a. Decedent's Usual Occupation						16b, Kind of Business/Industry				
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be file	Department or treatment are writer regards. The most treatment or fleme 23a or 28a-f show any injury or other traumatic event, the Middeal Examiner must be notified at once.	Be	17. Father's Name	First, Middle,	Last)								(First, Middle			16)		
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s 1 and f Health item 27			20a. Method of Disp	position				Place of Disp cemetery, cre	osition (Na	me of	e)	0	ate	20c. L	ocation -	on - City or Town, State		
Pages nent of th			1 🗆 Burial 2 l			yal from S	State/ I	hesape	•		· .	1/	24/05	Be	ltsv	ille,	MD	
permit. Departm Importa		Ì	21. Signature of Fu	meral Service	Licenson	1/0	11/1/2	2-/2	2. Name a	nd Addres	s of Facilit	v						
0 83E			Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD												D 20	910		
	Н	1		rt failure. List	complication	that ca	aused the dea ach line.	ith. Do not er	nter the mo	de of dyin	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
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Exam			roodiling in doubly			Due to (or as a conse	quence of):										
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Sertitic	has been signed by the attending I ge 2 should be detached tor use as	/Me	IF FEMALE:		23c. l	3c. If yes, outcome of pregnancy								23d. Date of delivery				
leath atten		hysician/Me	in the past 12 months?			1 ☐ Live birth 2 ☐ Fetal death 3 ☐			□Ectopic pregnancy □ Other (specify)				Month			Day Year		
the cy		hysi	9 Unknown	_ N o		Unkno	Unknown											
The law requires that the death certificate has been signed by the attending p		ру Р	Part II. Other significant conditions contributing to death but not resulting in the						, ,					id tobacco use contribute to the cause of death?				
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VILGI F ician: The certificate												performed? death? 1 Yes 2 No 1 Yes 2 No			2 No			
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Phys or this	eral d	-	27. Manner of Deat	h	·						Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
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l or Attendi efter death. Director: A	Director:	Certification:	3 🗆 Suicide 4 🔲 Homicide	ce of Injury - At home, farm, street, factory, office 28f. Location City or T.							(Street and Number or Rural Route Number, own, State)							
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o the Hospital or Attending Physician: within 24 hours after death. o the Funaral Director: After this certific	ately t	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier 29c. Certifier 29d. Date signed (Month, Day, Year,												ated. the cause(s)				
To the Hospital within 24 hours e To the Funaral I	To the	Me	29b. Signature and title of certifier							29c. License number					29d. Date signed (Month, Day, Year)			
1	1	2	I Sheli he Tolka						D22309					Jan. 18, 2005				
57	V			Name and address *person who completed cause of death (Item 23a) (Type, Print) Dr. Phillip Poth 8013 Flower Avenue Silve								Silve	er Spring, MD 20901					
2	Sta	tė	31. Date filed (Mon				egistrar's Sign				-14 (1.	- 40	DITAG	- որ	, <u>r r118</u>	, , , , ,	20701	
Re	gistr		J	AN 25	2005	A	09000	M A	and!	•								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien@ | Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** , E90 1:30FM John Edward Ross, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Baitimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2□F Director 218-12-3014 Nov.19 1923 MDUsual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Madical Examinant ust be notified at 1 ☐ Yes 2X No Director MD Baltimore Cockeysville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10036 Hillgreen Circle 21030 ŲSA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Xes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ₩ Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Manufacturing permit. Pagas 1 and 2 should be fite Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic avant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Ross, Sr. Elsie Masureck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Chestnut Ridge Dr., Lutherville, MD 21093 of Disposition (Name of 20c. Location - City or Town, State John E. Ross, III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (\$pacify)
21 Orginature of Full of 11 Service Livensage MD Veterans Cemetery 1/28/05 Garrison Forest, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Bryan W. Clary

10 W. Padonia Rd., Timonium,

23a. Par II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Batween Onset and Death

Onset and Death Bryan W. Immediate Cau (Final disease or condition resulting in death) **Physician** MYELOGENOUS LEUKEMIE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cther (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Aftar 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signature and title of centries 29c. License number wy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2005 32. Registrar's Signature 31. Date filed (Month, 1911) State Registrar

			1 _ State	State of Marylan		artment of H			2005	. הודוד
			Registrar 1. Decedent's Name (First, Middle, Last)			tinoate or L	Jean	2. Date of Deat	h	3. Time of Death
	Physici: /Medic		Harold Edward Ridle	ey				January	19, 2005	8:40 AM
	Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or		th	4c. County of De	ath
			4601 Millbrook Rd.	7 - 4	t 4 h t- 4 h . 1	Baltimo			N/A	
	Funeral Director		5. Social Security Number 145-28-7100 Usual Residence of Decedent	7. Age (In yrs. 65	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	irthplace (State or Foreign Country) EW Jersey
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	a-fst	ctor	Maryland N/A		Baltim	ore				1 X Yes 2 ☐ No
	ith the or 28 e no	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	ath w	rall	4601 Millbrook Rd.			21212			United S	
	ter de item rer n	une	11. Marital Status 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No 		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (: n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
99	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	white
5-0	72 ho	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation	ndkina	16b. Kind of Busines	s/Industry
21215-0036	vithin ne. han *	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired		1	D 1	/51
ю В	filled within 72 hours after death with the Maryland Hygiene. Ather than "natural", or items 23a or 28a-f show ant, the M. Alcal Examplier must be notified.		17. Father's Name (First, Middle, Last)	5+	COTT	ege Presi		me (First, Middle, M		/Education
Maryland	ld be ental ked o	To Be	Harold Ridley, Sr.					Corcoran		
ary	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Extrodust matter must be notified an once.	-	19a. Informant's Name/Relationship (Typ	Postor of S	19b. Mailir	ng Address (Street a			City or Town, State	, Zip Code)
	and 2 salth a n 27 l		Rev. Eugene Geinzer/	Community	470	01 N. Chai	cles St.	Baltin	nore, MD	21210
Baltimore,	ges 1 r of He ffiter or oth		20a. Method of Disposition 1	20b. P	Place of Dispo	osition (Name of majory or other place Of New YO	rk	Date	20c. Location - City	or Town, State
ţ	t. Pag rtmeni rtant:	1	'4 ☐ Donation 5 ☐ Other (Specify)	Pro	vince c	of Soc. of	Jes Jan.	26,2005	Auriesvi	lle, New York
Ba	permi Depa Impo any ir once.		21. Signature of Funeral Service Licenses John O. Mitc	hell	22	2. Name and Addres Mitch 6500	elI-Wie York Rd	defeld Fu Balti	neral Hom more, MD	e. Inc. 21212
п			23a. Part Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.	h. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			71AL 11	UFARC	7/00		SAME
	Examiner		ſ	Due to (or as a conseq	uence of):					
	B P 1 S	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	nd nd transit	Examiner	Cause (Disease or injury that initiated events c.							
8760,	ate be executed thysician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
		edical	d.							
Box 6	ding se as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ancy				23d. Date of d	eliven
ă.		Physician/M	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the death ed by the atte detached for	hys	9 Unknown	9□ Unknown						
	es be	by	Part II. Other significant conditions cont	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		_	to the cause of death?
ord	v requir been si should	eted						1 L Ye		Probably 4 □Unknown
Vital Records,	a £ 8	Completed						24a. Was a autops perform	y prior t	autopsy findings available completion of cause of
[a]		e Co	25. Was case referred to medical				OC Plans of Da	1 3 10 2	!□No 1□Y	
	Physician: rthis certific ral director,	0	examiner?	ospital:	ER/Outpatier	nt 3 DOA Othe	ar-	eath Check on on. Home 5 Peside		necify)
n of	ding Phys J. Atter this funeral di	T :uc	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time or				w injury occurred	Joseph
Siol	Attending ir death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be		,,		res 2□No			
Division	l or Attendafter deatl	ertification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	Hospital 24 hours a Funeral i	O	29a. Certifier 1 Certifying Physi	ician: To the best of my kno	wledge, deat	h occurred at the tim	ne date and place	e and due to the ca	use(s) and manner	as stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edlcai	(Check only 2 Medical Examination)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my op	oinion, death occ	urred at the time, da	ite and place, and d	ue to the cause(s)
	To the Comp	ž	29b. Signature and title of certifier	10 1	• • • • •	29c. License	_	2	d. Date signed (Mo	nth, Day, Year)
•	T.		* Trouges X	. Jarmody	MI		c=1373	,	Januar :	21,2005
	10		30. Name and address of person who con	mpleted cause of death (lea	23a) (Type,	ON, M	2120	04 FA	neir X	pendy
	Sta		31. Date filed (Month, Day, Year) 5 20	32. Projistrar's Signa	iture	house s	-,/20	1/10	7 -1 -1 -1 (morcie
	Registr	ar	4 · · · · · · · · · · · · · · · · ·	1 Jacobs 2	~ /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amenditem#23a(b), per MD, G840, 2/8/05 TT State of Maryland / Department of Health and Mental Hygiere 05 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 23, 2005 Year **Physician** Russell 12:30 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore Frederick Villa Nursing Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 9. Birthplace (State or Fore Under 22, 1917 | West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖳 F 87 216-24-5341 Yrs. **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6797 Athol Ave. 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eric Maxey Lou Move 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6797 Athol Ave. Elkridge, MD 21075 Mrs. Hazel Lastner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. Dat 26, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Meadowridge Mem. Pk. 2005 Elkridge, MD * 4 □ Ponation 5 □ Other (Specify) 21. Sign it ve of the eral Service Licensee Kirkley-Ruddick Funeral Home P.A. 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Broncho-pneumonia Five days. disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Alzheimer's Dementia Years. Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ▼No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Coronary Artery Disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Parkinson's Disease 1 ☐ Yes 2 ☐ No 1 Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 Other (Specily) 2 1 ☐ Yes 2 ₩ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

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To the within 2

with the Maryland

27 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Mcdeal Examinar must be notified at

the attending physicien and hed for use as the burial-transit

detached

The law requires that the death certificate be executed

Hospital or Attending Physicien: ierel Director: After this certific filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Items 23

Baltimore, Maryland 21215-0036

N B Vellanki, MD; 9055 Chevrolet Drive, #100, Ellicott City, MD 21042. 31. Date filed (Month, Day, Year) JAN 2 5 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature Call of the

D 30469.

2005.

24,

January

Registrar

			1 - For Stete Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and Death		giene Reg. No.	01719
	Physici /Medic		1. Decedent's Name (First, Middle, Last, TOSEFIL B. R.					2. Date of De Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give NOLITE ARWNEL 140)	,		4b. City, Town, or	Location of Dea	th MARYLAN	4c. County of Dea	th fernool
	Funeral Director		212-30-8460	3M 2□ E	/ast birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	s. 8. Date of Bir (Month, Da Sept.	th ly, Year) 9. Bir 2, 1931 Mai	hplace (State or Foreign buntry) cyland
	show		Usual Residence of Decedent 10a. State 10b. County	_	y, Town or Lo		<u> </u>			10d. Inside City Limits
	the Ma 28a-1 s	Director	Maryland Anne Arum 10e. Street and Number	ndel	Miller	sville			10g. Citizen of What Co	1 Yes 2 No
	3a or		483 Old Mill Road			21108	3		United Sta	•
	death	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of Hi. f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No	14. Race - Ame	
900	toges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinat mat be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Mayes 2 No Na If Yes, Give Year or Dates 1950—	avy	I ☐ Yes 2 🔀 No	Specify:	no mean, etc.)		nite
Maryland 21215-0036	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	lent's Usual Occupa kind of work done d OO NOT use retired	uring most of wo	orking	16b. Kind of Business	Industry
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and	be file ntal Hy ad oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
N N	should nd Mer marks	To	Unknown 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a		ne Mary	er, City or Town, State, 2	Zip Code)
, M	and 2 ealth a n 27 is		Helen Robinson(Wi	· · · · · · · · · · · · · · · · · · ·				-	lle, Maryla	nd 21108
nore	ages 1 nt of H t: If itan r or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crametion 3 ☐ F	lemoval from State	lace of Disposemetery, cren	sition (Name of natory or other place on Memoria	э) - .	nate	20c. Location - City or	
altimore,	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or othar trau		'4 □ Donation 5 □ Other (Specify) 21. Signatur of Fundal Service Licens						Glen Burni	
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	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.		er the mode of dying ARTUR			rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	`		7			
Ŀ	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of j.					
oʻ	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,		edicai		d						
Box 6	that the death certifined by the attending of detached for use as	an/Me	23b. Was decedent pregnant	3c. If yes, outcome of pregna		Ectopic pregnancy			23d. Date of del	,
	the deal	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pregnant at time of d 9□ Unknown		Other (specify)			Month	Day Year
ds, P.O.	Se un e	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	iderlying cause give	n in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Vital Records,	law require as been sig 2 should b	Completed						24a. Was	an 24b. Were au	topsy findings available
E Re	The la	Com							rmed? death?	completion of cause of 2 No
	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	for	Othe	PI .	ath (Check only c		
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Sion	ttandir death. tor: Af the fu	icatio	2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y	es 2□No	206 Leasting (Change of North Co.	- (C - + + + - + + + + - + - +
<u>></u>	tal or Attanders after death al Director: ed in by the	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		City or Tov	Street and Number or Ru vn, State)	irai Houte Number,
	To tha Hospital or Al within 24 hours after of To tha Funaral Direc completely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medicel Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and plac- inion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To tha within 2 To tha complet	M	29b. Signature and title of certifies	ulu & MD		29c. License	number 336		29d. Date signed (Month	
	01		30. Name and address of person who co	empleted cause of death (Item	23a) (Type, I	Print)	W/2 217	110-124	PASANITAM	MD 21122
	Sta		31. Date filed (Month, Day, Year) 5	32. Redistrar's Signa	ture	pole	1130	10137	TATINDERVA	MD 21122
	Registr	ar	JULIA	1	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** SOLAA 3:20 PM HIRLEY 232000 JANUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner INDEL 8. Date of Birth Month, Pay, May 13 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF 213-46-0852 65 Yrs. MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 7731 West Drive USA Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ö 1 ☐ Yes 2 No Specify: White Maryland 21215-0036 3 Widowed 4 X Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 01ive James Sands Thompkins ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 7731 West Drive, Glen Burnie, MD 21060 Theda H. Briemann (sister) other Baltimore. Date 24 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Jan. to 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Metro Crematory Inc. Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 2005 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days tricular /Medical **Examiner** my ocar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. ja Lipe detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown eu mon 10 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dieg 4 Momicide 24 hours a 1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 hc To the Fun completely f To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number les its mer

DHMH 17 Rev 1/2001

State Registrar North

Burnie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Thomas Shuron

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05-00553 RPD 1- For Unpend Registrar	Item	23atate of Manyland/ Depagaentos Hes	gith and Mental Hygiene

	RPD		For Unpend Item 2. - State Registrar	33,27,284 F per	Certifi	cate of Death	u Mentai riyy Re	2005 01721
	Dhunini		1. Decedent's Name (First, Middle, Last)				2. Date of Deat	
	Physici /Medic		THOMAS	M		URON	January	22, 2005 0710 P M
	Examin	er	4a. Facility Name (If not institution, give : 4320 Clareway Apai			City, Town, or Location of a	Death	4c. County of Death
9	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last	birthday) If I	Jnder 1 Year If Under 24		9. Birthptace (State or Foreign
	Director		211-27-0816	M 20F 75	Yrs.	nths Days Hours	Min. (Month, Day, MAY 27	1929 MARYLAND
′ –	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Locatio	n		10d. Inside City Limits
	Maryland -f show lind at	tor	MARWAIN W	14		BALTIM	DOE C	1 TYes 2 No
	h the or 28a a noti	irec	10e. Street and Number		10	of. Zip Code		Og. Critizen of What Country?
	death with the rms 23a or 28a rmast be noti	Funeral Director	4320 CLARE		A	210	2/3	45A.
	er de i	nue		12. Was/Decedent Ever in U.S. Armed Forces?	13. Was if Yes	Decedent of Hispanic Origin , specify Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	 Race - American Indian, Black, White, etc.
5-0036	hours after death with the Maryla ural', or Itams 23a or 28a-f shov Il Exsoring must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	101	es 2X No Specify:		Specify: BLACK
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	e filec al Hyg other	Be C	17. Father's Name (First, Middle, Last)				Name (First, Middle, M	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, I've M	To	VACHEL	SHU	RON	MAA	21/	CAMPBELL
lar	2 sho		19a. Informant's Name/Relationship (Ty				- (-	City or Town, State, Zip Code)
	ss 1 and 3 of Health litem 27 r other tr		GLORIA BARNWE. 20a. Method of Disposition		of Disposition	MOUNTHOK	Date SAZ	TTHORE MD 2/2/ 20c. Location - City or Town, State
Baltimore,	Pages nent of h ant: If its ary or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	ceme	etery, cremator	y or other place)		-ANSDOWNE, MARYLAN
Balt	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licens	11. 12 illian	22. Nat	ne and Address of Facility	BROWN J.	R, FUNERAL HOME BALTO, MD. 21217
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Carbon Monoxid Due to (or as a consequent) Due to (or as a consequent)	le Into: ce of):		rdiac or respiratory arre	st, Approximate Interval Between Onset and Death
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9	entifica ing ph e as th	Medical	IF FEMALE:					
.O. Box	at the death certificate be execu by the attending physician and tached for use as the burial-tra	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ecto	pic pregnancy er (specify)		23d. Date of delivery Month Day Year
Δ.	g g g	by Ph	Part II. Other significant conditions con	ntributing to death but not resultin	g in the underly	ring cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
rds	w requires been signi should be						1 □ Ye	s 2 No 3 Probably 4 Unknown
Records,	e law r has be je 2 sh	Completed					24a. Was ar autopsy perform	prior to completion of cause of death?
Vital	sician: Th certificate irector, pag	0	25. Was case referred to medical			26. Place of	1 Yes 2	□ No 1 □ Yes 2 □ No
of V	Physician: this certific ral director,	ToB	examiner? 12 Yes 2 No	lospital: 1 Inpatient 2 ER	Outpatient 3	DOA Other: 4 Nursi	ing Home 5 🗆 Resider	nce 6 Xother (Specify) At Scene
ion o	ng fter		27. Manner of Death 1 □ Natural 5 □ Pending 2 📆 Accident investigation	Foundh, Day Year) Fo	b. Time of outrid 45 P	28c. Injury at Work? 1 ☐ Yes 2 👿 No	Gas stov purposes	e on for heating
Division	To the Hospital or Attendi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Sertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify) Home				eet and Number or Bural Route Number,
	Hospita 24 hours Funera etely fille	edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowled	dge, death occi and/or investig	urred at the time, date and pation, in my opinion, death	place, and due to the ca	
	다른다른	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month, Day, Year)

State Registrar JAN 25 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A DATE (Iled (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signatura

32. Registrar's Signatura 32. Registrar's Signature

January 23, 2005

		1 - For Stata Registrar		nd / Depa	artment of Health and tificate of Death	d Mental Hyg	•	01722
	dical	Decedent's Name (First, Middle Odell 4a. Facility Name (If not institution)	Junius		Stokes 4b. City, Town, or Location of D	2. Date of Deat Month		5 0026 AM
Exan Funer Directo		SINAL HOS, 5. Social Security Number 218–28–6569		TMORE last birthday) Yrs.	BALTIMORE (If Under 1 Year If Under 24 H	CITY		thplace (State or Foreign ountry)
after death with the Maryland or Itams 23a or 28a-f show miner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD NA		ity, Town or Lo				10d. Inside City Limits XXYes 2 □ No
th with the 23a or 28s	Funeral Director	10e. Street and Number 4605 Homer A	ve		10f. Zip Code 21215	1	0g. Citizen of What Co	
ING Z IZ 15-UU30 be filed within 72 hours after death with the Marylan hall Hygiene. hall Hygiene. d other then "natural; or Itams 23a or 28a-f show event, Ire Mayleal Examiner must be notified at	by Funer	3 ☐ Widowed 4 ☐ Divorced	If Yes Give		Vas Decedent of Hispanic Origin? I Yes, specify Cuban, Mexican, Pt ☐ Yes 2 🌠 No Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
d ZIZI3-003 filed within 72 hours Hygiene. hther then "natural", ant, the Medical Exa	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 10th grade	t's Education st grade completed) College (1-4or 5+) na	(Give	ent's Usual Occupation kind of work done during most of ONOT use retired) Oly Operator	working	16b. Kind of Business Hospit	
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Te, Mar 1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relations Floyd Stokes— 20a. Method of Disposition	NepHew 20b.	1061	g Address (Street and Number of Harbor Cour sition (Name of	t, Sykes	-	21784
Datilinore, Marylis permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke eny injury or other traumatic	once.	1 XBurial 2 Cremation 4 Donation 5 Other (5	Specify) Ga	rrison	Forest Vet Name and Address of Facility SCH Wabash Av	1//28/05	Owings N	Mills. Md
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ate be executed Example of the control of the contr	je.		b. DIABET Due to (or as a consect C. Due to (or as a consect d.	quence of):	AUTUS			YEARS
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
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The larate has	Comp					24a. Was ar autops perform 1 \supersection Yes 2	y prior to death?	utopsy findings available completion of cause of 2 No
on On ling Phys h. After this funeral di	atlon: To Be	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ZER/Outpatient 28b. Time of Injury	Othor	g Home 5 Theside 28d. Describe ho	nce 6 🗆 Other (Spe	cify)
> 4 - 8 Q	Certification:	3 Suicide 6 Could determ		nome, farm, stre	eet, factory, office	28f. Location (Str City or Town	reet and Number or Ro , State)	ural Route Number,
To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Medical	(Check only 2 Medical one)	ng Physicien: To the best of my kn Examiner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my opinion, death o	ccurred at the time, da	ite and place, and due	to the cause(s)
V	~	•	/ (m	m 22c\ /T 1	29c. License number D005158 (/ 20	TANUARY &	22 2005
45	State	30. Name and address of person CTCR 31. Date filed (Month, Day, Year,	who completed cause of death (Ite	ature	AL HOSPIT	th of B	ALTIMORE	=
	istrar	JAN 2	2005 Mesers.	B. A	and a			

			For State		Department of Health and I	Mental Hygier	1e) 11 15	01723
			Registrar		Certificate of Death	Reg. I	No.	01720
	Physici	an	1. Decedent's Name (First, Middle, Last)	Same	t		Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		2 2005 4c. County of Death	
	LAAIIIII	CI	2460 11/00der	off Rd	BALTIMOR		BALTIN	
	Funeral		Social Security Number 6. Security Number	(11 000 = 1 1 1	thday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	9 Rinth	place (State or Foreign intry)
	Director		129-60-1004	IM 2□F 64	Yrs.	(Month, Day, Yea	O IK	AN
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
	Mary Ff eh	tor	MD BALTIN	MORE	BALTIMORE			1 ☐ Yes 2 No
	th the	irec	10e. Street and Number	0: 0:	10f. Zip Code	10g. (Citizen of What Cou	intry?
	ath wi	rai	2460 Wood C		21234.		USA	
	er deg	nne		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
36	irs att	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: TRA	Alidal
5-0036	72 hours atter death with the Maryland naturel', or items 23e or 28e-f ehow liteal Examinar must be natified at	ted	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupation	16b.	Kind of Business/Ir	
21	within 7 ene. then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	Q Q	1.10	, 0
121	filed with Hygiene ther the		17. Father's Name (First, Middle, Last)	4 10	It enployed		tail- Te	rsianny
anc	ould be f Mental H arked ot etic ever	Be c	Malan	Sanati	7 - 6	ne (First, Middle, Maid	an Sumame)	•
Maryland	and Me	To	19a. Informant's Name/Relationship (Ty	Janati oe, Print) 19b	Mailing Address (Street and Number or Ru	(CU) ral Route Number, City	y or Town, State, Zi	p Code)
	1 and 2 Health a tem 27 is		Elsa Janati - u	sife 2	the woodcroft Rd	Harkvill	C.MOZ	1234.
Baltimore,	of He of He if item or oth	M. O	20a. Method of Disposition 1	eomotor	Disposition (Name of y, crematory or other place)		Location - City or T	
ţ	thent of tent: If it		'4 Donation 5 Other (Specify)	Dulan	24 Valley Men. On 1-2 22. Nam and Address of Facility 232	5-05 T	imon : um	MD.
Bal	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylar Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other then "naturel", or items 23e or 28e-f ehow any injury or other treumetic event. If a Madical Examiner must be natified at any injury or other treumetic event. If a Madical Examiner must be natified at another.		21. Signature of Funeral Service License	201	22. Name and Address of Facility 232	5 YORICRO	TIMONIC	M.MD ZIOB
		0 1	23a. Part1. Enter the disease, or complete	cations that caused the death. Do r	PCHUTUL HUKRNAM not enter the mode of dying, such as cardiac	or respiratory arrest.	CHLOCKE	MATTON CENTS Approximate
	Physician		Immediate Cause (Final	e cayse on each line.	IRE See to Circh	10001	1400	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	of):	05/5 7	1004	
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(ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence	of):			
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68760,	icate be executed physician and s the burial-transit	dicai		Pour Nederlar	9			
-	rtificate ng physi as the l		IE EE WIE					
Вох	death certific e attending p ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnancy	15	23d. Date of deliv	,
	0 0 2	ysici	1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month	Day Year
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Records,	uries n sign	d by				1 🗆 Yes	2 □ No 3 □ Prol	pably 4 \(\begin{array}{c}\)Unknown
000	s been si	ojete				24a. Was an	24b. Were auto	opsy findings available
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of V	8 S	2	1 ☐ Yes 2 Ø No	ospital: 1 Inpatient 2 ER/Ou		ome 5 Residence		(y)
	ding Ph h. After thi funeral	tion	27. Manner of Death 1 Natural 5 Pending investigation		ime of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	ury occurred	
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Ö	s after	Certification:	4 Homicide	building, etc. (Specify)		City or Town, Sta	te)	
	lospit hour unere		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	, death occurred at the time, date and place, droi investigation, in my opinion, death occur	and due to the cause	s) and manner as s	tated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely tilled in by the fune.	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number			
	- 8 H 8 H	-	> mobiled for	Ç	•		Pate signed (Month,	-
	h		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print) M 5 C A 4 // //	Mala	1 27, x	,
					8817 Bell	DOW/A	1200 BALL	m/2(236
	Sta	_	31. Date filed (Month, Day, Year)	32. Radisitar's Signature	1 0			/
	Registr	ar	JAN 2 5 20	UD Bloker D.	108012)			

	State of Maryland / L	Certificate of	Death	Reg. No.	J5 U1/25
1. Decedent's Name (First, Middle Physician	e, Last)			ete of Death Jonth Day	3. Time of Death
/Medical John H. Sch	wallenberg Jr.		Jb. City, Town, or Location	an. 22, 2 of Deeth 4c. County	005 4:15 am
4a Fecility Name (If not institution Manor Care			Rossville		timore
Funeral 5. Social Security Number	6. Sex 7. Age (In yrs. lest bir	thdey) If Under 1 Year		ate of Birth fonth, Dey, Year)	9. Birthplece (State or Foreign Country)
Director 215-28-2823	10 X M 2□ F 72	Yrs. Months Days	Hours Min. (M Se	pt. 28,19	32 Md.
Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
Md. Bal	timore Edge	emere			1 ☐ Yes 2√∑ No
10e. Street end Number		10f. Zip Code		10g. Citizen of	Whet Country?
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To a. State 10b. County 10c. State 10b. County 10c. State 10	12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	ispanic Origin? (Specify Y In, Mexican, Puerto Rican, Specify:	, etc.) Bla	ce - American Indian, ck, White, etc. y: White
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8 yrs. 17. Fether's Neme (First, Middle,		Laborer	18 Mother's Name /Fire	Stee.	
Tohn Schwal			Emma Haze		hompson
19a. Informant's Name/Relations	hip (Type, Print) Wife 19b	. Mailing Address (Street	and Number or Rurel Rout	te Number, City or Town,	State, Zip Code)
Annamae Sch			ay Rd. Edg		
	3 Linemoval from State	Disposition (Name of ry, crematory or other place Hill Cem	Jan	. 25	City or Town, State
Section 1 Service 21. Signature of Funeyal Service 21. Signature of Funeyal Service 22. Signature of Funeyal Service 23. Signature of Funeyal Service 24. Signature of Funeyal Service 25. Signature 25. Signatu	-				dle River
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e general cause. Enter Underlying cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Lest	CDue to (or es e d	consequence of):			
A O O O O O O O O O O O O O O O O O O O	d				
eath cee eath cee			an in Paral	Oak Did takense use se	ntribute to the ceuse of death?
The death cert of the death ce	ns contributing to death but not resulting in	n the underlying cause giv	en in Part I.	1 ☐ Yes 2 ☐ No	3 Probably 4 ⊅ Unknown
be defined by D					
The law requires that the death conditions that the death conditions that the death conditions that the death cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Part II. Other significant conditions. Part II. Other significant conditions.			2	4a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?				1 L Yes 2000	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of Death (Che	ock only one)	
O S S S S S S S S S S S S S S S S S S S	Hospital: 1 Inpatient 2 ER/Ou		4 Mursing Home 3	Residence 6 Oth	
The property of the property o	g (Month, Day Year) I getion	Time of 28c. Injur njury Wor M 1□	y at 286. D k? Yes 2 □ No	escribe how injury occur	red
27. Menner of Death 1		rm, street, factory, office		ocation (Street and Numb ity or Town, Stete)	per or Rural Route Number,
हिंहें 📆 29a. Certifier 📲 Certifyin	g Physician: To the best of my knowledge Examiner: On the basis of examination en and manner stated.				
29b. Signature end title of certifie		29c. Licens		1 -	d (Month, Dey, Year)
10	1=	D	43725 KirerNe	1/2	4105
30. Neme end eddress of person	who completed cause of death (Item 23e)	(Type, Print)	Kiver No	ok RAR	alhin m
State 31. Dete filed (Month, Day, Year)	F 2001-32. Registrer's Signature	- 1 0 000	0. 100	Cic . Cox . 5	1,1,1,0,16

Registrar

				For 1_ State		aryland / Dep		Health and I	Mental Hy	giene ()	05	01726
		_		Registrar 1. Decedent's Name (First, Middle, Las	t)		Timeate of	Death	2. Date of De	Reg. No.		3. Time of Death
		Physici							Month	Day	Year	M
		/Medi Examir		Barbara R. Schnei 4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of Death	Januar		2005 ty of Death	9:05 AM
6		Exami	.c.	Gilchrist Center	for Hospi	ce Care		Towson		Ral+	imore	
125		Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		place (State or Foreign
1.		Director		066-24-2584	□M 2XF	78 Yrs.	Michinia Buyo	Tiodis Willi.	06/07/		CT	
9		and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
0		Maryi i sho	jo	NV		5.5.3						1 ☐ Yes 2 No
8		r 28a	Director	NY Erie 10e. Street and Number		Buffalo	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
-		death with the Maryland ms 23a or 28a-1 show rmust be notified at		703 W. Ferry, Apt	Δ15		14222			USA		
3		deat ems	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No		ace - Americack, White,	
	36	or It		1 Never Married 2 Married	1 ☐ Yes 2 ☐X If Yes, Give	No	1 ☐ Yes 2 🕅 No		o vilouri, oto.,	Spec		eic.
3	Ö	hours tural',	d by	3 Widowed 4 Divorced	Year or Dates:						Whit	
3	7	in 72	jete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor id)	king	16b. Kind of		dustry
4	212	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or:	5+)	maker	-,		Own Ho	me	
Barbara	Þ	a filec al Hyg othe	BeC	17. Father's Name (First, Middle, Last)		Mone	MONET	18. Mother's Nam	ne (First, Middle,	Maiden Suma	ıme)	
^	<u> a</u>	uld by Menta Menta Mrked	To	Frank Leon Riehle				Helen Co	orrin Goo	ode		
3	Maryland 21215-0036	2 sho and I is ma	ľ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	n, State, Zip	Code)
3		and ealth m 27		Elizabeth Cannon/	aughter)			Road Ruxt				
9	Baltimore,	ges 1 t of H if itel		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ca)	Jan 22	20c. Location	- City or To	own, State
6	ţ	tmen tant: tant:		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			ke Crema		2005	Beltsv	ille,	Maryland
Schneidun	Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 2008.		21. Signature of Funeral Service Licen	1 11	1000 4 8 0 I	2. Name and Addre Cremation	and Funer	al Alter	natives		
V)				23a Part1. Enter the disease, or comm	lications that caused		2717 Croon	Pactures	Drivo	Pal+imo	re, Ma	ryland Approximate
				23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each li	1	/	/				Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	a. Dua to (or a	a consequence of):	6 4	mpn	omA			morths
	П	Examiner				a consequence oi).						
			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
		sician and burial-transit	Examiner	that initiated events	c							
	760,	be execulician and burial-tran		resulting in death) Last	Due to (or as	a consequence of):						
	876	e X	dicai		d							
	Вох 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				201.0	-44-1	
	Bo	atten for u	cian	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnanc	у			ate of delive lonth	Day Year
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		s that ned b a deta	by Pł	Part II. Other significent conditions co	ntributing to death b	ut not resulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did to	obacco use co	ntribute to th	ne cause of death?
	rds	quire; nn sig uld be							1 🗆 1	res 2 No	3 ☐ Prob	ably 4 Unknown
	CO		piet						24a. Was			psy findings available
	R	ding Physician: The lar h. After this certificate has funeral director, page 2	Completed							med?	death?	impletion of cause of 2 □ No
	ita	ian: artifica ctor, g	BeC	25. Was case referred to medical examiner?			333	26. Place of Dea				1
) V	Physician: this certific ral director,	2	1 ☐ Yes 2 No		ent 2 ☐ ER/Outpatie	" SEI DOA		ome 5 Resid	dence 6 00	her (Specif	n Hospice
	n	ding P. After t funera	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Wo		28d. Describe h	now injury occu	irred	
	Sio	tend leath tor: /	cat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be	CO. Disease (1)	A15		Yes 2 □ No	004 Landing //	24		15 1 N
	Division of Vital Records,	or A after Direc in by	Certification:	4 Homicide determined	building, et	ury - At home, farm, st c. (Specify)	reet, lactory, office		City or Tou	vn, State)	iber or Hura	I Route Number,
	_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, deat	h occurred at the til	me, date and place	and due to the	cause(s) and m	anner as si	ated.
		s Hoi 24 h e Fur letely	edical	(Check only 2 Medical Exam	iner: On the basis o	f examination and/or in	vestigation, in my o	pinion, death occur	rred at the time, a	date and place	, and due to	the cause(s)
		To th To th comp	Me	29b. Signature and title of certifier	1	1	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
	, (/	7	M. Antha	ing the	ly, uno	02	2302		Janun	my di	12005
		Con la constitución de la consti		29b. Signature and title of certifier 30. Name and address of person who of the state of the st	ompleted cause of	leath (Item 23a) (Type,	Print)	0 51	2.01	201	7.2	- 6
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	()		at Data liked Atlanta Day Your	G-BMC	6701	W. Chr	ule St.	Tauto.	Ma	212	
	de	Sta Registi	ite rar	JAN 2 5 2005	22. negistr	di s digitatul e	de					
			e .	7								

			Registrar	State of Maryland / De	partment of Health and Nertificate of Death	lental Hygien	The second secon	7
	Physici /Medic		Decedent's Name (First, Middle, Last) RUTH AMANDA SHIPL	EY		2. Date of Death Month 01/18/20	ay Year 3. Time of Death 02:20 I	
	Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			THE WESLEY RETIRE		MT. WASHINGTON		BALTIMORE	
	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs. last birthday) M 2XIF 91 Yrs	Monthe Dave Houre Min	8. Date of Birth (Month, Day, Yee		eign
			Usual Residence of Decedent			08/16/1913	3	
	ryland how		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Lim	_
	Be-f s	cto	MD ANNE ARUN	DEL LINTHIC			1 □ Yes 2 X	No
	death with the Maryland ims 23a or 28e-f show	Funeral Director	10e. Street and Number 325 SCHOOL LANE		10f. Zip Code 21090	10g. C	itizen of What Country?	
	leath	erai		2. Was Decedent Ever in U.S. 1		ecify Yes or No-	USA 14. Race - American Indian,	
2-0036	be filed within 72 hours after death with the Marylar at the Hygiene. and Hygiene. and other than "natural", or liems 23a or 28e-f show other than "natural", or liems 23a or 28e-f show event, it a Madical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 [X] Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: WHITE	
2 C	72 ho	eted	15. Decedent's Educi (Specify only highest grade	ation 16a. De (G	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)	ina 16b.	Kind of Business/Industry	
7	ed within 72 giene. er than "nai	Completed	Elementary/Secondary (0-12)		e. DO NOT use retired) EMAKER		OWN HOME	
yland	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	n Surname)	
	should nd Men marke umatic	2	ROBERT J. NICHOLSO 19a. Informant's Name/Relationship (Typ)		KATHERIN ailing Address (Street and Number or Run	IE MAE COX	or Tourn State Tie Code)	
Mar	S a = 0	l V	MR. GLENN SHIPLEY		3 LINTHICUM LANE, I			
	s 1 and if Health item 27 other to		20a. Method of Disposition	20b. Place of Di			Location - City or Town, State	
Ê	mit. Pages partment of I portent: If it, / injury or o		1 Burial 2 Cremation 3 Re `4 Donation 5 Other (Specify)	illoval lioni State		1/2005 RAN	DALLSTOWN, MD	
Baltimore,	permit. Departnimporte any inju		21. Signature of Funeral Service Licensee	V 11	22. Name and Address of Facility SI 1 SECOND AVE. SW, G		NERAL HOME, PA , MD 21061	
	Physician /Medical Examiner		23a. P. ∰t1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	caus on each line.	enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death	
=	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				- 1 NA
O. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year	
ds, r	juires that n signed b ild be deta	by	Part II. Other significant conditions cont Coroney arting	nbuting to death but not resulting in the	e underlying cause given in Part I. The Heart Fails	23e. Did tobacco	use contribute to the cause of death?	wn
Hecord	The law requires that the ate has been signed by th page 2 should be detache	Completed	Hypertersin	Parlemm's	Disere	24a. Was an autopsy performed?	24b. Were autopsy findings availat prior to completion of cause of death? 1 □ Yes 2 □ No	ble
Vital	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			(Check only one)		
5	Physician: this certific ral director,	2	10 165 22 140			me 5 Residence		_
	ding I h. After funer	tion	27. Manner of Death 1 S Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how inj	ury occurred	
Division	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 to completely filled in by the funeral director, page 2.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
	se Hospite n 24 hours ne Funere pletely fille	edical (29a. Certifier (Check only one) 2 Medicel Exemina	cien: To the best of my knowledge, deer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cause(ed at the time, date ar	s) and manner as stated. In place, and due to the cause(s)	
	To the To the compl	ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Dey, Year)	
	İ		P. T. Ju	luto, us.	121464		1-19-05	
	\wp		30. Name and address of person who con	npleted cause of death (Item 23a) (Type	oo, Print) wh St Beello.	pul 2,	1214	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature)			
	Registr	rar	IAN 2 5 200	DE Bear H	Acort. 2			

PD			1 - For State Registrar	State of Marylan	-	artment rtificate			nd Mental H	lygien		5	01	728
	Physici	an	1. Decedent's Name (First, Middle, Last)	l mm a					2. Date of Janua		ĭ, 20) (18 5		of Death
Н	/Medic Examin		Kenneth Joseph Si 4a. Facility Name (If not institution, give si Northwest Hospital			4ь. city, Randa		ocation of		40	altim	of Death	1 0,3,	
	uneral irector			7. Age (In yrs. 51	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Hrs. 8. Date of (Month, April	Birth Day, Year 2, 1	953	Cour	olace (State otry) L., M	e or Foreign D
ne Maryland	Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimore		y, Town or Lo sterst	own				•			1 □ Ye	City Limits es 2⊠No
with th	3a or 2	a Dire	10e. Street and Number 819 Nicodemus Rd			10f. Zip	Code 136			10g. C	itizen of W USA		ntry?	
036 urs after deat	trof Health and Mental Hygiene. If item 27 is marked othar than "natural", or items 23a or 28a-f show or othar treumetic event, the Medical Examinar must be notilled at	by Funeral	11. Marital Status 1 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2톤 No If Yes, Give Year or Dates:		Was Deced If Yes, spec	ify Cuban,	oanic Origi Mexican, Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-		, White,		
1215-0 within 72 ho	than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give	dent's Usua kind of wor DO NOT us	k done du		of working		Cind of Bus			
Baltimore, Maryland 21215-0036	Mental Hygi arked othar atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Jack Simms	-			1		s Name (First, Mid rgaret La	dle, Maide				
Mar d 2 sho	th and 27 is m treum		19a. Informant's Name/Relationship (Type Doreen Matias-Simi	,					or Rural Route Nu eistersto				Code)	
more,	Department of Heali Importent: If item 2 any injury or othar once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disponentery, cre	osition (Nan matory or o	ne of ther place)		Date 1/26/05	20c. l	ocation · (City or To		
Balti permit.	Departm Importe any inju once.		21. Signature of Funeral Service License		2	2. Name an Eline	d Address	of Facility	1182	24 Re	ister	stow		6
//	ysician Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	eations that caused the deat e cause on each line. ATKEROSCU Due to (or as a conseq	EROTLO						EASE		Approxim Interval B Onset an	Between
	physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t										
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ords, P.O	been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	underlying c	ause given	in Part I.		id tobacco □ Yes 2		bute to t	he cause o	of death?
Rec	ate has	Completed							24a. W an po 16 Ye	utopsy erformed?	pi		ppsy finding impletion o	gs available t cause of
of Vital Physician: T	is certificate director, pag	o Be	25. Was case referred to medical examiner? 1XX es 2 No	ospital: 1 ☐ Inpatient 2 🗓	ER/Outpatie	ent 3 DC	Other		of Death (Check on sing Home 5 ☐ R		6 □Othe	r (Specia	(v)	
Vision of Attending Phy	들	ertification; T	27. Manner of Death 1 Autural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury a Work?	at	28d. Descri				97	
Division	24 hours after death. • Funere! Director: After etely filled in by the funer	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy) 					Town, Sta	re)			umber,
- Hospital	within 24 hou To the Fune completely fi	dical	29a. Certifier (Check only one) 1 Certifying Phys Medical Examir	ician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred nvestigation	at the time in my opia	, date and nion, death	place, and due to to occurred at the tire	the cause(ne, date ar	s) and mar nd place, a	ner as s nd due t	stated. o the causi	9(s)
Toth		Me	29b. Signature and title of certifier			- 1	C.M.I			1	ate signed	•	Day, Year 2005)
	13		30. Name and address of person who co	mpleted cause of death (Iter	п 23ај Туре	Penn	Stree	et, B	altimore,	Mar	yland	212	201	
	Sta Regist	ate rar	31. Date file ANth 2º 45 Year 2005	32. Registrar's Sign	ature	Se la la la la la la la la la la la la la								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ADTMILLER JANUARY 21, 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOSPITAL If More CI HOPKINS APRIL 12, 1945 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1 M 2 ☐ F Months Days Hours 080-34-284 14 **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director TuTTle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A 73089 994 COUN Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Ves 2 No
If Yes, Give
Year or Dates: 6 2 - 6 4 Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: WHITE Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BCK SMITH IENANCE 1ó 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame STADTMILLER CARD J. DOROTHY CITARIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAMS-994 COUNTY ST 2910 TUTTLE WIFE VICKIE OK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Deportment of H Important: If ite any njury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State BAHO, MD METRO CreMATORY * 4 ☐ Donation 5 ☐ Other (Specify) 1-25-05 22. Name and Address of Facility Fren St. P.A. Michgel Zighier Fren St. P.A. P.O., Box 67338- BAHO MD. 21. Signature of Funeral Service Licensee P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ORGAN FM /Medical Due to (or as a consequence of): **Examiner** ONGESTIVE oquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death Check onl one examiner's 1 ☐ Yes 2 🗙 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day) Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records. Division of Vital

Box 68760.

P.O. I

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRICS. WETSS, MD POBOX 110 TOWER, 600 NORTH WOLFE STREET,

JAN 25

32. Registrar's Signature



29c. License number

29d. Date signed (Month, Day, Year)

21287

BALTIMORE, MARYLAND

			1 - For State O	Maryland / Dep	ertificate of			ene g. No. 2005	01730
Ī	Physici		1. Decedent's Name (First, Middle, Last) David S. Smythe				2. Date of Death Month Jan. 11,	Day Year	3. Time of Death
	/Medic Examin	al	4a. Fecility Name (If not institution, give street and nur	nber)	4b. City, Town, o	or Location of Deall	1	4c. County of Deeth	
			1804 Newcastle Road		Windsor			Baltimore	
B	Funeral Director		5. Social Security Number 125–22–7527 6. Sex 2□ F	7. Age (In yrs. last birthda)	Months Days		8. Date of Birth (Month, Day, Nov. 2,	Year) 9. Birthp Cour 1931 New Yo	lace (State or Foreign htry) DTK
	ס		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation				0d. Inside City Limits
	Maryla f ahor	ro	MD Baltimore	Windsor					1 ☐ Yes ∑2∑ No
	or 28e	lrec	10e. Street and Number	WINGSOI	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	23a c	raiD	1804 Newcastle Road		21244	•		USA	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28e-f show aumatic avent, the Medical Exams are must be confiled at	by Funeral Director		² □No1953	i. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert Specify: Whi		14. Race - Americ Black, White, Specify: Wil	
S O	72 ho 'natur	Completed	15. Decedent's Education (Specify only highest grade completed)	/Gis	edent's Usual Occu e kind of work done	during most of wor	king	6b. Kind of Business/Inc	dustry
121	within ene. then	idmo	Elementary/Secondary (0-12) Cotlege (1	-4or 5+) Engine	DO NOT use retire	9d)		Westinghous	se
<u>5</u>	I Hygie other	Be Co	17. Father's Name (First, Middle, Last)	75		1	ne (First, Middle, M		
ylar	should be nd Mental marked o	ToE	Howard Vincent Smythe				e Lafner		
Maryland 21215-0036	s 1 end 2 should f Health and Mer tlam 27 is marke other traumatic		James Kohlhepp- Son					City or Town, State, Zip ena, Maryla:	
Baltimore,	Peges 1 er nent of Hea int: If item iry or other		20a. Method of Disposition 1 □ Burial 2€Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	20b. Place of Dis Balemetery of Loudon P	position (Name of ematory or other place)	Jan.		20c. Location - City or To	
Baltii	permit. Peges Depertment of Important: If it any injury or o		21. Signature of Funeral Service Cicensee		22. Name and Addr	ess of Facility LO		Funeral Ho , Maryland	
R			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause the	aused the death. Do not e	nter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	A/Coho/	ABuse				Onser and Death
	Examiner			Alcohol	ic cor	dioryop	asky		
	pe #s	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of):			1		
(j.	te be executed ysicien and le burial-transit	Examiner	that initiated events	or as a consequence of):					
68760,	9 × 9	dicai	d						
O. Box	The law requires that the death certifica sie has been signed by the attending ph page 2 should be delached for use as in	Physician/Med	in the past 12 months?	ant at time of death 5	□Ectopic pregnand □ Other (specify) _	су		23d. Date of delive Month	ery Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to de Several U/C23	eath but not resulting in the	underlying cause gi	iven in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
Records,	sician: The faw requir s certificate has been s lirector, page 2 should	Completed	Alcoholic CA	ROIOMY	posty		24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
Vital		Be C	25. Was case referred to medical			26. Place of Dea	th (Check only one		
	Physic this co	ို	1 ☐ Yes 2 ☐ Hospital: 1 ☐ I	npatient 2 ER/Outpati	ent 3 DOA	ther: 4 Nursing H		nce 6 Other (Specify	γ)
on	Attending Physician: or death. ector: After this certification by the funeral director.	ıtlon		th, Day Year) Injury	Wo	ork?]Yes 2 □No	28d. Describe ho	w injury occurred	
Division of	al or Attai s after dea il Director od in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place buildi	of Injury - At home, farm, s ng, etc. (Specify)	street, factory, office)	28f. Location (Str. City or Town,	eet and Number or Aura State)	I Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical		best of my knowledge, deasis of examination and/or ner stated.	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as si te and place, and due to	tated. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier		29c. Licen	Se number	/	ld. Date signed (Month,	1
,			30. Name and address of person who completed caus	se of death (Item 23al/Tun	a Print\	25A1VA	BAY	PR 1415	105
_	10		7/4/ Security	Blval	Baltin	we !	40 2	1244	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 5 2005	legistrar's Signature	al)	/			

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sinai Baltimore Hospital 09 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth DEC. 10, 1920 **Funeral** Days Hours Min. 1 M 2 □ F 84 219-05-0865 Yrs. **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Steinber r than "natural", or itams 23s or 28s-f show the Medical Examinar must be notified at Be Completed by Funeral Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 2703 GLEN AVENUE 21215 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 MYes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ifted within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) ORTHODONTIST other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental h is markad . Peges 1 and 2 should by ment of Health and Menta tent: If Itam 27 is marked jury or other traumatic expenses. STEINBERG LENA SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES S. AARON / DAUGHTER 6350 RED CEDAR PLACE #306 - BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Importent: If any injury or once. *4 □Donation 5 □ Other (Specify) BETH EL MEMORIAL PARK 1/24/2005 21. Signature of Fureran Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hyard failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** edema DU/monary /Medical Due to (or as a consequence of): Examiner heart estive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner

1. Decedent's Name (First, Middle, Last)

LEON

Physician

/Medical

Amend item#19a, perFH G839, 1/25/05 TT State of Maryland Department of Health and Mental Hygiene 15

STEINBERG

Certificate of Death

Reg. No.

3. Time of Death

MD

10d. Inside City Limits

1 X Yes 2 ☐ No

10:00

N/A

Birthplace (State or Foreign Country)
 MD

USA

WHITE

BORDANSKY

Approximate Interval Betwe

Onset and Death

2 days

Year

2005

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

ORTHODONTICS

20c. Location - City or Town, State

RANDALLSTOWN, MD

14. Race - American Indian.

2. Date of Death

Month

January

23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

21,2005

JANJURY

attending physicien and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the signed by the a To the Hospital or Attanding Physician: After thi death. Diractor:

Completed by Physician/Medical

Be

P

Certification:

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

State Registrar

JAN 2 5 2005

Sinui 32. Paistrar's Signature

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

D.O.

28a. Date of Injury (Month, Day Year)

9 Unknown

Lymphonia

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.

Gardyn

rena

5 Pending investigation

6 Could not be

4□Pregnant at time of death

Hospital of Baltimore 2401 W. Belvedere Ave

3 Ectopic pregnancy

3 DOA

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

RES-000

5 Other (specify)

within 24 hours a To the Funaral D

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			1 - For State of Maryland	/ Depa		lealth and		giene 0 0 5	01732	
	Physicia /Medic		Decedent's Name (First, Middle, Last) ALEXANDER		SCHARF	•		ŹŐ, 20Ŏ		
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of De BETHE:		4c. County of Death		
	Funeral Director		SUBURBAN HOSPITAL 5. Social Security Number 062-01-0068 Contact Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h		9	Birthplace (State or Foreign Country) NY	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Lo	eation				10d. Inside City Limits	
	Mary a-f sho	tor	MD MONTGOMERY	ROCK	VILLE				1 □ Yes 2 🔀 No	
	ith the	Direc	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha		
	leath v	erai	6111 MONTROSE ROAD 11. Marrital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of H	20852	(Specify Yes or No-	14. Race - A	USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23e or 28e-f show any injury or other treumatic event, Ite Madical Examiner must be notified at once.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 M No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 🗖 No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black, V	WHITE	
5-0	"natu	ietec	15. Decedent's Education 1 (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Busine	ess/Industry	
Maryland 21215-0036	d withing jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DRIV		"		TAXI		
nd	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)	0.0111			Name (First, Middle,	Maiden Sumame)	1/1 T NOED	
<u> S</u>	hould id Men marke matic	수	MORRIS 19a. Informant's Name/Relationship (Type, Print)	SCHA		REBECI	CA Rural Route Numbe	r City or Town Sta	KLINGER	
	and 2 saith an 127 is		STEVEN SCHARF / SON		_		VE - GAITH			
Baltimore,	ges 1 a t of He if item or othe				sition (Name of matory or other place			20c. Location - City		
<u>=</u>	it. Pa intmen intent: njury njury		'4 □ Donation 5 □ Other (Specify) MT . N 21. □ Consture of Funeral Dervice Licensee		H CEMETER	-	/24/2005			
Ba	Depa impo any id		Michael Trugel				SOL LEVINS N ROAD - F		E, MD 21208	
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one gause on each line.	Do not ent	er the mode of dyin	g, such as card	diac or respiratory arr	est,	Approximate Interval Between	
a	enysician /Medical		resulting in death)		AR FIBRIL	LATION			Onset and Death	
	Examiner		Due to (or as a consequent		FROTIC CO	RONARY	ARTERY DI	SEASE		
	ם וו	iner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ice of):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	xecute n and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequent or injury)		DEMIA				11	
8760,	sate be executed obysicien and the burial-transit	ical E	d							
Вох 68	death certificate be executed e attending physicien and id for use as the burial-transit	ba -	IF FEMALE: 230 If yes, outcome of progression							
Bo	that the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
P.O.	at the call by the stached	hysi	9 ☐ Unknown							
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.		_	e to the cause of death? Probably 4 XUnknown	
Vital Records,	The ate h page	Completed			· · · · · · · · · · · · · · · · · · ·		24a. Was a autops perfor 1 □ Yes	sy prior med? deat		
Vita	yeiclen: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 My oc. 2 The Hospital:		A _ Oth		Death (Check only or	-/		
	Attending Physicien: r death, sctor: After this certifice by the funeral director, I	n: To	27. Manner of Death 28a. Date of Injury 28	Outpatier b. Time of Injury			g Home 5 Reside	ence 6 □ Other (\$ ow injury occurred	Specify)	
sior	or Attending after death, Diractor: After in by the funer	catio	2 Accident investigation		M 1 🗆	Yes 2 □ No				
Division of	in Diffe	ertification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	e, farm, str	eet, factory, office		28f. Location (Si City or Town		r Rural Route Number,	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Diractor: After th completely filled in by the funeral	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, deatl and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death or	ace, and due to the c ccurred at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		29c. Licensi		2	9d. Date signed (M	onth, Day, Year)	
	N		1 to Delcom		MD 4	40576		JANUARY	21, 2005	
V)		30. Name and address of person who completed cause of death (Item 23 RAMIN OSKOUI, M.D.		Print)					
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 2005	Soa	w					

State of Maryland / Department of Health and Mental Hygiene 1 01733 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 23 JANUARY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TOPKIN 1 Hmore John HUSPITA If Under 1 Year Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F -20-6195 Director d Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, If a Modical Examiner a ust be natified at Baltimore MD 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö 208 or Items 23g by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Black 3 Widowed 4 ☐ Divorced Specify: "neturel" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then eny injury or other treumetic event, It a Manan injury or other treumetic event, It a Manan Elementary (Secondary (0-12) College (1-4or 5+) cology atn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James C. Robinson 011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) + a uine Grove, UA 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other 1 Burial 2 □ Cremation 3 Removal from State butus Mem. * 4 □Donation /5 □Other (Specify) 21. Signature o. 6 neral . rvjće Li se see 22. Name and Address of Facility 21229 Balto mb 23a. Part J. Ef her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPEXIA hours /Medical Due to (or as a consequence of): Examiner Pulmonary y ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit certificate be executed Interstifial 41915 that initiated events resulting in death) Last Dulmonary Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 2 1 Nnpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 X Natural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lynette Brown M. D. Ph. D. January 22, 2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital Wolfe, Baltimore, Maryland 21287 Lynette Brown 31. Date filed (Month, Day, Year) 32. Restrar's Signature State 2005 Registrar

			For State Registrar	State of Marylan			of Health a of Death	ind Ment		ene 0 0 5	5 01734
	Physicia		1. Decedent's Name (First, Middle, Last) Dorothy Belle Un	derwood					eate of Death Month INUARy	28, 20ŏ	3. Time of Death 10:55 A M
	/Medic Examin		4a. Facility Name (If not institution, give s The Wesley Home 2	treet and number) 211 W. Rogers	Ave.	-	wn, or Location o	f Death		4c. County of I	Death /A
	Funeral Director			M 2∏F 7. Age (in yrs. 100	last birthday) Yrs.	If Under 1 \ Months D	ear If Under 2 ays Hours		ate of Birth Month, Day In . 19,	(027)	Birthplace (State or Foreign Country) ennsylvania
	death with the Maryland ms 23s or 28a-f show frivat be notified at	tor	Usual Residence of Decedent		y,Town orLo		**************************************				10d. Inside City Limits
	or 28a	Directo	10e. Street and Number		TI-THOIL	10f. Zip Co			109	g. Citizen of Wha	it Country?
	eath v	Funeral	2211 W. Rogers Av	enue 12. Was Decedent Ever in U	S 13.1		209	nin? (Specify)	Yes or No-		SA American Indian,
036	I 2 should be filed within 72 hours after death n and Mental Hygiene. I is marked other than "natural", or liems 23 reaumatic event, the Modical Exterimetrials	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 ∑No If Yes, Give Year or Dates:		if Yes, specify	t of Hispanic Orig Cuban, Mexican KNo <i>Specify:</i>	, Puerto Ricar	1, etc.)		White, etc.
Maryland 21215-0036	hin 72 ho s. n. "natu Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual (kind of work (DO NOT use i	ione dunna most	of working	16	6b. Kind of Busin	ess/Industry
21	ygiene ygiene her tha	Сош	12	4	Sch	ool Te				Educa	tion
and	d be fill ental H ked ott	To Be	17. Father's Name (First, Middle, Last) Frederick Soloman	n Cramer						aiden Sumame) McMullii	
ary	s f and 2 should f Health and Mer item 27 Is marke other traumatic	_	19a. Informant's Name/Relationship (Type	oe, Print)			treet and Numbe	r or Rural Rou	ite Number, (City or Town, Sta	
	0 = : =		John Underwood 20a, Method of Disposition	Son		Kilgo: sition (Name	re Court	Jopp.	-	yland :	21085
altimore,	Pages nent of P int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crer	valley	r place)	/24/20			il le, Maryland
Balti	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature Funeral Service License	Henss) 22 B	Name and Aurgee-I	ddress of Facility Ienss-Se	itz Fu			nc. 21211
>	Physician /Medical		23a. Part1. Enfor the disease, or complishock, of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line. END-STAG Due to (or as a conseq	h. Do not ent	er the mode o	f dying, such as o	cardiac or res	piratory arres	it,	Approximate Interval Between Onset and Death
8760,	cate be executed by the physician and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	L-YC S uence of):	1)/50	ASF				Y-CARS
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic preg				23d. Date o Month	f delivery Day Year
_	quires that n signed by		Part II. Other significant conditions cor	stributing to death but not res	ulting in the u	nderlying caus	se given in Part I.		23e. Did toba 1 □ Yes	× ^	ite to the cause of death? Probably 4 □Unknown
Il Records,	: The law require cate has been si page 2 should i	Completed							24a. Was an autopsy performe	ed∮? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	sician s certifi lirector	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other a f	of Death (Chi) ce 6 □Other ((Spanify)
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. I		v injury occurred	Specily)
Divis	ial or Atte s after dea al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, str y)	eet, factory, o	ffice	28f. L	ocation (Stre Dity or Town,	eet and Number o State)	or Rural Route Number,
	Hospit 24 hour Funera tely fills	Medical (29a. Certifier Certifying Physical Check only one)	sicien: To the best of my knoner: On the basis of examina and manner stated.	wledge, death	h occurred at vestigation, in	he time, date and my opinion, deat	d place, and d th occurred at	lue to the cau the time, dat	use(s) and manne e and place, and	er as stated. I due to the cause(s)
	fo the within 2 to the comple	Mec	29b. Signature and title of certifier	And marmer stated.		29c. L	icense number		290	d. Date signed (A	Month, Day, Year)
	./		Koher E. Va	oley St. N	1-D.	D.	1942	5		1/20	12005
	5		30. Name and address of person who co	npleter was of death (Iter	n 23a) (Туре,	Print)	GEPS 1	ANE -	BAITI	MORE	MD 2/209
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	2.40	<u> </u>	-	-11011	1	, (

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year VANBRAKLE ANITA MARTIN JAN 15 2005 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 229-20-4596 82 Yrs Director Dec 9, 1922 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Montgomery Rockville 1 ☐ Yes 2 ▼ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or itams 23a 254 N. Washington Street #116 death 20850 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after al Hygiene. I other than "natural", or ital 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ۵ Specify: white 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) conference manager 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Ia marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Biggers Martin 2 Ethel Lee Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry vanBrakle/daughter 1645 International Drive #104 McLean, VA 22102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service License 22. Name and Address of Facility D. Pleasant Anthony State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician PULMONARY HYPERTENSION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2**X** No To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation М 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ME-88648 (FL) Jan 18, 2005 2176 30. Name and address of person who completed cause of death (Item 23a) Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 DAVID_M.BRETT-MAJOR LCDR MC

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death Month nuary 8, 2005 **Physician** 53 /Medical 4b. City, Town, or Location of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) **Funeral** Fareign Days Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Exertine Internative rigitied at To Be Completed by Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 5 or Itams 23c Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. PO NOT the retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. 90 yege (1)40r 5+) Elementa/v/Secondary (0-12) r's Name (First, Middle, Last) and Mental H Department of Health ar Important: If item 27 Is any injury or othar trau a. Method of Dispo 1 Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune/al Service L Party. Enter the disease, or complications that call shock, or heart failure. List only one cause on ear Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Year Month Day signed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Partill. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in his short. death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO017537 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARShan Saluja, M.D. 1600 M.M. Boyal Ave. Balto, md. RShan 160.

Registrar

31. Date filed (Month, Day, Year)

32. Regis ar's Signature

		ļ	1 - For State Registrar	State of Maryland		nt of Health and		2005	01737
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (thot institution, give s	Wongus	4b. Cit	y, Town, or Location of Deat	2. Date of Death Month JAN 4 ATCT	Day Year 14th 200	
	Funeral Director		SAINT AGNES +11	EALTHCARE		PALTIMOR er 1 Year If Under 24 Hrs	₹	9. Birth	aplace (State or Foreign untry)
	72 hours after death with the Maryland natural', or Itams 23s or 28s-1 show dical Exama natinual be motified at	Director	10a. State 10b. County Maryana 10b. Street and Number	10c. City, 7	Town or Location Caltime	Ore lip Code	10g	J. Citizen of What Cou	10d. Inside City Limits 1 StYes 2 □ No untry?
920	ours after death with the Manylar ral', or Itams 23a or 28a-1 show Examinational be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:		edent of Hispanic Origin? (Secrify Cuban, Mexican, Puerl	specify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	f within iene.	Completed	15. Decedent's Edución (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	work done during most of wo	rking 16	b. Kind of Business/li	ndustry
Maryland	2 should and Mer Is marke aumatic	To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Ty,	V. Turner	19b. Mailing Addre	18. Mother's Nar	ne (First, Middle, Mai	iden Sumame) 190 d Ay of Town, State, Zi	ip Code)
Baltimore, N	Pages 1 an nent of Heal ant: If Item 2 ary or other		20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State 600	ce of Disposition (Netery, crematory of	ame of other place) Forest /3.4 and Address of Eacility	AUR. Date 2005	C. Location - City or T	iown, State Mills, Md.
	Departing Importation Importat		23a. Pant. Enter the disease, or complishdock or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death.	Do not enter the ma	hy horths		ral Han	Approximate Interval Between Onset, and Death I Week.
Ki	/Medical Examiner sicien and purial-transit	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):				1
Box 68760,	ate the	hysician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 mpnths?	Due to (or as a consequer Due to (or as a consequer I	y path 3⊟Ectopic			23d. Date of deliv	<i>re</i> ry Day Year
ords, P.O.	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as	by P	1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions con	9□ Unknown		cause given in Part I.		cco use contribute to t	
of Vital Records,		Be Completed	25. Was case referred to medical examiner?			26. Place of Dea	24a. Was an autopsy performed 1 Yes 2xth (Check only one)	prior to co death?	opsy findings available ompletion of cause of
sion of V	ling Phys	ertification: To I	1 Yes 25 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		VOutpatient 3 C 3b. Time of Injury M	OA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No	ome 5 ☐ Residence 28d. Describe how i	e 6 □Other (Speci injury occurred	fy)
Division	tospital hours a uneral l	edical Certific	3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check only) 2 ☐ Medical Examir	28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowle her: On the basis of examination	edge, death occurre	d at the time, date and place	City or Town, S	se(s) and manner as s	stated
)	To the Hos within 24 ho To the Fun completely	Medi	29b. Signature and title of certifier	M D	29	P (6+05	29d.	Date signed (Month,	Day, Year)
	Sta Registr		30. Name and address of person who co ANTHON' BAFFE-B 31. Date filed (Month, Day, Year) IAN 2 5 2005	mpleted cause of death (Item 23 SON NIE – SATH 32. Registrar's Signature	IT ACINES	HEALTHCA	RE RACTI	imore, M	ARTUANS

Wongus, CARCOLYN

05-00339 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a_PII_27_perME_C839_1/26/05_TT State of Maryland / Department of Health and Mental Hygiene DAVID WASHINGTON 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 14, JAN. 2005 1335 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2310 EAST NORTH AVENUE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Days | Hours | Min. | /(Month, Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 214-72-8395 Usual Residence of Decedent 100 M 2□F Yrs. Director arning death with the Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Modical Executate in ust be retified at Maryland Director NaYes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: [_ þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Be Oper Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). if itam 27 rington other VYA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages 1 Department of H Importent: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Funeral Service Licensee 21. Signature 22. Name and Address of Facility Home Joseph Balto. 1 North 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the (9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Alcoholism 1 Yes 2 No 3 Probably 4 Qunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 🗆 No Hospital or Attanding Physician: 25. Was case referred to medical examiner?

1X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence \(\text{XOther (Specify)} \) 2 3□ DOA AT SCENE 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 🗌 Natural 1 🗌 Yes 2 🗌 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗍 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) and manner stated. To tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E JAN. 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

2. Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND 21201

		For		State of Maryla				Mental H	ygiene	Logibio.	
		1 - State Registrar 1. Decedent's Name	(First Middle Last)		Certi	ficate of L	Death	2. Date of D	Reg. No.	005	01739
Physi		Maco	or Co +	. West	-1011			Month	Day		3. Time of Death
/Med Exam	dical niner	4a. Facility Name (If	not institution, give st			b. City, Town, or	Location of Dea			County of Death	1
		3009	Moores	Rd.		BAL	DWIN			HARFOR.	D
Funera Directo		5. Social Security Nur	10 6. Sex	M 200 F		f Under 1 Year fonths Days	If Under 24 Hr Hours Mir	n. (Month, L	irth Day, Year)	COL	nplace (State or Foreign Intry)
) I	Usual Residence of D	CCD		01			10-6	-20	MAR	CYLHOUS
anylan	_	10a. State	10b. County	10c. C	ity, Town or Local	ion					10d. Inside City Limits
death with the Maryland oms 23a or 28a-f show ir must be notified at	ecto	10e. Street and Numb	HARFO	ed L	- BAL	10f. Zip Code	_		10- Ciat	f \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1 ☐ Yes 2 No
with 38 or	ā	200	Moores	Rd			013		Tog. Citi	zen of What Cou	intry r
death	Funeral Director	11. Marital Status		2. Was Decedent Ever in Armed Forces?	U.S. 13. Wa			(Specify Yes or Norto Rican, etc.)	lo-	14. Race - Amer Black, White	ican Indian,
s after , or Ite	by Fu	1 Never Married	^	1 ☐ Yes 2 No If Yes, Give Year or Dates:		Yes 2 No	Specify:	nto moan, etc.,		Specify: 1,	h Lo
IC X IX IS-UUSO If lied within 72 hours after death with the Marylar I Hygiene. other then "natural", or Items 23a or 28a-f show rent, I've Medical Evantice mast be notified at		3 Widowed 4	5. Decedent's Educa		16a, Deceden	t's Usual Occupa	ation		16b. Kir	nd of Business/Ir	ndustry
A LO	Completed	(Specify	only highest grade lary (0-12)	completed) College (1-4or 5+)	(Give kin life. DO	d of work done d NOT use retired,	furing most of w)	orking			,
be filed within tal Hygiene.		17. Father's Name (A	Adjusted to a seal		nonce	maker	10 14 15 1 11		a	- nonco	,
• 4 to 5 e	Be	Dahact	Keari	75				ame (First, Middi	e, Maiden	Sumame)	
ire, INGLYICI s 1 and 2 should be if Health and Menta ttem 27 Is marked other traumatic e	2	19a. Informant's Nan			19b. Mailing	Address (Street a	7	PLINCL Pur I Route Num	ber, City or	Town, State, Zi	ip Code)
and 2 salth a n 27 is		BARDARA	TANE ZIN	Khan-daug	3009	Moore:	s Rd.	Kaldu	in 1	40 2	1013
0 %°= 5		20a. Method of Dispo	sition Cremation 3 □Re		Place of Dispositi cemetery, cremat	on (Name of ory of one) place	IR	Date	1	cation - City or T	own, State
Dallino permit. Pages Department of Important: If I		4 □Donation 5	Other (Specify)	EVA	NS FUNE	RALCHAI		35-05			411 MO
Depart Impo	ouce	Kim	110,0, 1	2 10/1	PEN						OM MOZIOSZ TIONCENTER
Wast.		23a. Part1. Enter the	disease, or romolic failure. List only on	sion I that caused the de	ith. Do not enter	the mode of dying				HUCOMIN	Approximate Interval Between
Physicia	n	Immediate Cause (F	1	LUNG	ANYS	R				6	Onset and Death
/Medica	_	resulting in death)		Due to (or as a conse	quence of):						1 11010 1113
Aum		Sequentially list conditions if any, leading to imm	litions, b.	Due to (or as a conse	quence of):						
uted	Examiner	cause. Enter Underly Causa (Discass or in that initiated events	/ing								
e exection and interpretation and unital-tr		resulting in death) La	st	Due to (or as a conse	quence of):						
cate be e	dical		d.								
ecords, F.O. BOX 66/700, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent p	reonant 23	c. If yes, outcome of pregr					2	23d. Date of deliv	renv
death death e atte	lclai	in the past 12 m	onths?	1 Live birth 2 Fel		topic pregnancy ther (specify)				Month	Day Year
at the d by th	Physician/M	9 Unknown		9∐ Unknown	***						
	1 by	COPD	ant conditions cont	ributing to death but not re		RTENSI	1		Yes 2	V	the cause of death? bably 4 Unknown
taw requires as been sign	letec		DIABET	c c	17916	121031	0.00	24a. Wa			
age he age	Completed							aut	opsy formed?	death?	opsy findings available ompletion of cause of
VICAL icien: T certificat ector, p	BeC	25. Was case referre examiner?		AR DISEA	52		26. Place of De	1 ☐ Yes eath (Check only		1 Tes	2□ No
Of VICE Physicien: rthis certific	P	1□Yes 2XN	o Ho				ar: 4 ☐ Nursing			Other (Speci	fy)
After fune	lon:	27. Manner of Death	5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? /es 2 □ No	28d. Describe	how injury	occurred	
VISION Attending or death. rector: After	ertification:	2 Accident 3 Suicide	investigation 6 Could not be determined	28e. Place of Injury - At I	home, farm, street		165 2 140	28f. Location	(Street and	d Number or Run	al Route Number,
al or /	Certi	4 Homicide	Gerenninea	building, etc. (Spec	ify)	, , , , , , , , , , , , , , , , , , , ,		City or To	own, State)		
To the Hospital or Attending Physicien: To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 (Check only 2 one)	Cartifying Physi Medical Examine	cian: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death or nation and/or inves	curred at the tim tigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time	e cause(s) , date and	and manner as s place, and due t	stated. to the cause(s)
To the within To the	Me	29b. Signature and til	le of certifier	•		29c. License	number		29d. Date	signed (Month,	Day, Year)
		Lou	sE. 14	elsen mi	0	D38	327		//	24/05	mark.
7	0			pleted cause of death (Ite	em 23a) (Type, Pri	n*\		#201		1.000.1	400 21201
'	2404	2015 E. A	Dav. Year)	32. Ramistrar's Sign		PIER	KE DR	1) 206	10	WSON	modbox
Regi	State strar	J.	N 2 5 200	32. Rapistrar's Sign	& Sp						
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DHMH 17 Rev 1/2001

ORIGINAL

			For		State of M	Marylan		artment of I		Mental Hy	ygiene	005	0171.0
			State Registrar				Ce	ertificate of	Death		Reg. No.	000	01/40
	Physicia	an	Decedent's Name	(First, Middle, Last,)					2. Date of D	Day	Year	3. Time of Death
	/Medic			Edith Wat						JANUA	Ry o	2001	21:40 M
	Examin	er	4a. Facility Name (If I	not institution, give	street, and number	ar)	_	4b etty, Town,	or Location of Dea	th	4c.	County of Death	1
			5. Social Security Nu	76/06S	HEALI	Age (In yrs.	C	of Under 1 Year	17/MOCE	8. Date of B	1-46-	0.0:4	(2)
	Funeral Director		•	10	X]M 2⊠F		Yrs.	Months Days	Hours Min	(Month, D	Pay, Year)	Col	nplace (State or Foreign untry)
			220-40-75 Usual Residence of D			61				Feb.14	1943	Mary	Land
	yland		10a. State	10b. County		10c. City	y, Town or I	ocation					10d. Inside City Limits
	Mar-fish	tor	Maryland	Baltimore	2	Ca	tonsv	ille					1 ☐ Yes 2 ☐ No
	ath with the Marylan s 23a or 28a-f show ust be rectilised at	Director	10e. Street and Numl	ber				10f. Zip Code			10g. Citi	izen of What Co	untry?
	23a c		723 Edmo	ndson Ave	enue			212	28		USA		
	after dea or Itams	Funeral	11. Marital Status		12. Was Decede Armed Force	s?	.S. 13	. Was Decedent of I	Hispanic Origin? (S	Specify Yes or N	10-	14. Race - Amer Black, White	
98	or It	y Fu	1 Never Marrie		1 ☐ Yes 2 { If Yes, Give	₽No		1 ☐ Yes 2 ☑ (No		, , , , , , , , , , , , , , , , , , , ,		Specify: Wh	
8	72 hours after death with the Maryland natural; or Itams 23e or 28e-f show lical Exantratic Letterilled at	d by	3 Widowed 4		Year or Date	s:							-
<u> </u>	"nat	Completed	(Specif	15. Decedent's Edu y on <i>ly highest grad</i>	cation e completed)		16a. Dec	edent's Usual Occu e <i>kind</i> of <i>work d</i> one DO NOT use retire	pation during most of wo	rking	16b. Ki	ind of Business/I	ndustry
2	withii ene. than	щć	Elementary/Second	dary (0-12)	College (1-40	or 5+)		emaker	۵)			Own Hom	
9	filed Hygi othar ant, t		17. Father's Name (F	First, Middle, Last)			110111	emaker	18. Mother's Na	me (First, Middl			е
an	ld be ental ked c	To Be	Robert Le	e Phillip	s				Tillie	Mae Ke	rns		
Maryland 21215-0036	shound Mind Mind Mind	-	19a. Informant's Nan	me/Relationship (T)	rpe, Print)		19b. Mai	ling Address (Street				r Town, State, Z	ïp Code)
₹	nd 2 lith a 27 le r trau		Cecil Wat	con	ī	Juchan	723	Edmondso	n Avenue	Catons	27/11	o Mary	land 21228
ā,	s 1 a f Hea item otha		20a. Method of Dispo	osition		20b. P	lace of Disp	position (Name of ematory or other pla		Date		ocation - City or 1	
ê E	Page ent o nt: If ry or			Cremation 3 □F □ Other (Specify)		te	-	wn Mem.Ga		8/2005	Marr	iottsvi	11e. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after der popartment of Health and Mantal Hygiene. Important: If item 27 ie marked other than "naturel", or Items any injury or other traumatic event, It a Mould. Extending once.		21. Signature of Fun					22. Name and Addre	ass of Facility				
ä	Deparent Dep		dist	_ S lle	- the			Sterling 736 Edmo	Ashton ndson Av	Schwab] enue: Ca	Funer	al Home	Inc. MD 21228
			23a. Part1. Enter the	e disease, or compl failure. List only o	ications that caus	sed the deatl	h. Do not e					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between
	Pnysician	i n	Immediate Cause (F	inal	al	who	in los	Livit	100.00				Onset and Death
	/Medical		resulting in death)		a Due to (o	as a conseq	uence of):	- 1 1 4 (14)	ven	orrha	ge		1 14
	Examiner		Sequentially list con-	ditions							0.020		
1	ם א	Examiner	Sequentially list cond if any, leading to imm cause. Enter under	ying	Due to (or	as a conseq	uence of):						
6	be executed ician and burial-transit	cam	Cause (Disease or in that initiated events resulting in death) La		C								
60,	be ex clan a		rooming in double, and		Due to (or	as a conseq	uence or):						
09289	cate phys the	dical			d								
E ×		/Me	IF FEMALE:	2	23c. If yes, outcor	ne of pregna	incv					22 d Data of dali	
BB	the death certif y the attending iched for use as	by Physician/M	in the past 12 m 1 Yes 2	pregnant	1 ☐ Live birth	2 Feta	I death 3	☐Ectopic pregnand ☐ Other (specify)	у		1 '	23d. Date of deli- Month	Day Year
30	the thec	ıysi	1 □ Yes 2 ≥ 5 9 □ Unknown	No	9☐ Unknowr		040.						
AG	that ed b deta	P	Part II. Other signific	cant conditions co	ntributing to deatl	h but not res	ulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
Sp.	law requires as been sign 2 should be			lyna	CAMO	en				1 🗆	Yes 2[□No 3 Pro	obably 4 □Unknown
(5 S	w requir been si should I	lete		J						24a. Wa	s an	24b Were aut	topsy findings available
Record	iician: The lav certificate has rector, page 2	Completed								auto	opsy formed?	prior to o death?	ompletion of cause of
	ificate or, pa	e C	25. Was case referre	ad to medical					OC Place of Do	1 Yes		1 🗆 Yes	2 No
Si	Physician: r this certific ral director,	To B	examiner?		Hospital: 1 ☐ Inpa	ationt 2	ER/Outpati	ent 3 DOA Ot	26. Place of De	ath (Check only		€ □Other /Spec	ih.)
1	y Phys er this eral di	T:U	27. Manner of Death		28a. Date of I	niury	28b. Time	of 28c. Inju	ry at	28d. Describe			19)
ω_{l}	Attanding F r death. actor: After by the funer	atio	1 Natural 2 Accident	5 Pending investigation	(Month,	Day Year)	Injury		rk?]Yes 2.⊟No				
Vis	Attand or death actor: / by the f	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	Injury - At he etc. (Specifi	ome, farm, s	treet, factory, office		28f. Location	(Street and	d Number or Rui	ral Route Number,
Ō	s afte	Certification;	4 I Homeldo		Dungang,	etc. (Specii)	y)			Only or 10	Jwn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		29a. Certifier (Check only 2	Certifying Phy Medical Exami	sician: To the be	st of my kno	wledge, dea	th occurred at the ti	me, date and place	e, and due to the	e cause(s)	and manner as	stated.
	tha H in 24 tha F iplete	Medical	one)	- Inociocal Externi	and manner	stated.	tion andor			arred at the time			
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Σ	29b. Signature and ti	itle of dertifier			1	29c. Licen	se number		29d. Dat	e signed (Month	, Day, Year)
	6,		ryan	Montalle	MO E	HA O	endin	9 [006151	54	0	1-21.	-05
			30. Name and addres	ss of person who co	ompleted cause of	of death (Item	11	N.	E 1	200 -	1	۸ -	
			31. Date filed (Month	Day, Year)	32. Regi	istrar's Signa		Abres	ED	700 4	TUN	me	
	Sta Registr					on o orgina	le 2	7					
			JA	N 2 5 200	13 Page	are d	J. A.	20062					

			Amend i	Please tem#2,per	Type or Pring 14 Control of March 14 Control o		Indelible ink Department of I		II Copies <i>A</i> l ental Hygi	ene Legible.	01761
	Physici	an	Registrar	e (First, Middle, La	st)		Certificate of	Death	2. Date of Death Month	01/19/20	3. Time of Death
	/Medic Examin	al	4a. Facility Name (arie Weis If not institution, giv Maris Ho	e street and number)		4b. City, Town,	or Location of Death	01/	29/ 2005 4c. County of De Baltim	
	Funeral Director		5. Social Security N 212-22- Usual Residence of	4545 6. S		e (In yrs. last birt		If Under 24 Hrs.	8. Date of Birth (Month, Day, 05/04/19	Year) 9. B	inthplace (State or Foreign Country) Maryland
	f show	or	10a. State	10b. County		10c. City, Towr					10d. Inside City Limits
3	a or 28a. De notifi	Director	MD 10e. Street and Nu		<u>u</u>	Falls	10f. Zip Code		10	g. Citizen of What (Country?
9500	permit. Pages 1 and 2 should be lied within 72 hours after deeth with the maryland. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If liem 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other treumatic event. The Medical Examinar must be notified at once.	by Funeral	11. Marital Status	gle Road	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		21047 13. Was Decedent of If Yes, specify Cut 1 Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wh Specify:	
<u>ה</u>	n /z nou n "netura Aedical E	Completed		15. Decedent's E	ducation ade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	ing 1	6b. Kind of Busines	hite ss/Industry
7170	Hygiene.	a l	Elementary/Secondary	(First, Middle, Last	College (1-4 <i>o</i> r 5		ales Clerk	18. Mother's Nam	e (First, Middle, M		ent Store
yland	Mental Mental Marked	ToB		m L. Keim		7			Anne Hole		
ore, mar	es 1 and 2 sn of Health and f item 27 le m r other treum		Beatri 20a. Method of Dis	P	_	O:	Mailing Address (Stree ne Ed ewate Disposition (Name of y, crematory or other pla	er Drive -	Middleto		sylvania17057
Danimor	permit. Page Department Importent: If any Injury o		° 4 ☐ Donation	5 ☐ Other (Special uneral Service Lice	5)	Metro		ess of FacilityE.	F. Lassal	nn Funera	1 Home, P.A.
	nysician /Medical Examiner	Je.	shock, or her Immediate Cause disease or conditi- resulting in death)	art failure. List only (Final on	a. OVARIAN Due to (or as	ne.	of enter the mode of dy				yland 21087 Approximate Interval Between Onset and Death
ō .	certificate be executed ording physician and tse as the burial-transit	edical Examine	if any, leading to it cause. Enter Und that initiated event resulting in death)	S	c	a consequence o					
ם	atter for u	hysician/Medic	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of d Month	lelivery Day Year
ecords, P	n requires that the di been signed by the should be detached	by P	Part II. Other sign	ficant conditions	contributing to death b	ut not resulting in	the underlying cause g	iven in Part I.			to the cause of death? Probably 4 X Unknown
L Kec	Ine far ate has page 2	Completed							24a. Was an autopsy perform 1 Yes 2	ed? prior to	autopsy findings available of completion of cause of caus
_	ng Phy fter this neral d	ertification: To Be	25. Was case referexaminer? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No	28a. Date of Inju (Month, Da	y Year) Ir	ime of 28c. Injury	ther: 4 Nursing Houry at ork? Yes 2 No	28d. Describe how	nce 6 X Other (Sp w injury occurred	necify) HOSPICE Rural Route Number,
ź.	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	4 Homicide	1 ▼ Certifying P	building, et	c. (Specify) of my knowledge	, death occurred at the t	ime, date and place,	City or Town,	State)	as stated.
	o the Horithin 24 h	Medical	(Check only one) 29b. Signature and	2 Medical Exa	miner: On the basis o and manner sta	examination and	d/or investigation, in my	opinion, death occur se number	red at the time, da	te and place, and di	ue to the cause(s)
	- s ⊢ ŏ		00 Non-		11		DU	13725		1/20,	105
	Ψ		DR. TA	RIO MAHMO		ULANEY V	Type, Print) ALLEY RD.	TIMONIUM,	MD 2109	3	
	Sta Regist		31. Date filed (Mo.	JAN 2 5	2005 32. Red tr	ar's Signature	Sparker				

sicia	n_	Decedent's Name (First, Middle, La					2. Date of D Month	eath Day	Year	3. Time of Death
edica		Alyce L. Wilhel						24 20		7:20 A
mine	er	4a. Fecility Name (If not institution, giv	e street and number)			n, or Location of De	ath		County of Dea	
-1		College Manor 5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)		erville ar If Under 24 H	rs. 8. Date of B	irth	altimor	
ral tor			1□ M 2□ F 82	Yrs.	Months Day	ys Hours Mi	May 1	Day, Year)	3 1	thplace (State or Forei ountry) AD
		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limit
	cto	MD Baltim	ore	Luthe	rville					1 Yes 2 N
	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of Whal C	ountry?
	ara.	300 W. Seminar	1)M D	21093	(C 4 - V 1		USA	aniana tantina
	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces?	1.5.	If Yes, specify Co	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes of Nerto Rican, etc.)	10-	4. Race - Ame Black, Whi	
	Ď	3 Widowed 4 □ Divorced	1 ☐ Yes A☐ No If Yes, Give Year or Dates:		1□Yes 2□X	to Specify:			Specify: W	hite
	Completed	15. Decedent's E			dent's Usual Occ		nduna.	16b. Kîn	nd of Business	/Industry
	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ne during most of w ired)	rorking			
	Sol	12	n/a	Dep	t. Mana	_			tail Cl	othing
	Be	17. Father's Name (First, Middle, Last,					ame (First, Middl	le, Maiden S	Sumame)	
	ို	Morris F. Har		101 11 11		1	d Beck	, 0:		
ı		19a. Informant's Name/Relationship (19b. Maili	ng Address (Stre	eet and Number or . 's Ln., '	Rural Route Num	ber, City or	Town, State,	Zip Code)
1	1	C. Suzan Bur	20b. I	Place of Dispo	osition (Name of		Date Date		/ 8 / / pation - City or	Town State
1		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory`or other p	Jali	. 27,		•	
1		* 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Lifety			Cremato 2. Name and Ado	and the same of th	005	Fall	s Chui	rch, VA
Ц				2	Lemmon	Funeral	Home of	Dula	ney V	alley, Inc. 1093
KIIKE	\dashv	23a. Part 1. Enter the disease, or com	agle	th. Do not en	0 W. Pa	donia Rd tving, such as card	ac or respiratory	nium, arrest.	MD 2	1093 Approximate
	- 1		11100111110	カニ	MENTIA					Interval Between Onset and Death
	icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. VA SCHLAR Due to (or as a consect b. Lus to (or as a consect c. Due to (or as a consect d.	uence of):	MENTIA					
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Amend item#18,20b, perFH, G839, 1/25/05 TI
State of Maryland / Department of Health and Mental Hygiene

100 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician 22, 2005 3:05 A^M January Walker Inga A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Holly Hill Manor, Inc. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 3 F Yrs. Director 148-14-6119 Sept. 11 1925 76 Sweden Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show treumetic event, the Medical Examiner must be notified at 1√Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Itеms 23a Completed by Funeral 5701 Enderly Rd death 21212 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: lf Yes, Give Year or Dates: Specify: USA 3 ☐ Widowed 4 € Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Relations/Collections Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Suensson ပ Harry N. Anderson Judith M. Suenss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 is any injury or other trea Martha W. Vint/daughter 5701 Enderly Rd., Baltimore, MD 21212 Date 1/25/795 Location - City or Town, State 1/15/05 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition **№** Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Bryan W. Clary 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) accident Priysician ere 000 vascular hr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ę Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, should be cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 2**/2** No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after deat uneral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Thomicide filled in within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 51454 Hudelowan January 24, 2005 ana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1205 York Road, suite 38, Lutherville, Maryland Inna Gendelsman, M.D. 31. Date filed (Month, Day Naar 2 2005^{32. Registar's Signature} State 5 Coarles Registrar

Patricia Ruth Weinzirl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-00418 State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Patricia Ruth Weinzirl 18, 2005 4c. County of Death /Medical January 03.26 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □ KE Yrs Director 214-26-9294 76 May 7,1928 MD Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f ahow the Medical Examiner must be notified at Director 1 Yes 2X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 637 Glynlee Court 21136 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Examinating. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ Walter Peach Marie Catherine Migan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Weinzirl Son 637 Glynlee Court, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 1/20/05 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 7.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complications Atheroscierotic Cardiovascular **Physician** of disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ettending physicien Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an autopsy performed? certificete 1**X** Yes 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥Yes 2 □ No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA NIS. funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation ofter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: To the Hospital of within 24 hours of To the Funeral D completely

> State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 2 5 2005

29b. Signature and title of certifie

29a. Certifier

(Check only one)

tamela

Southall, MD. . Registrar's Signature

outhall, mp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

January 18, 2005

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registral JAN 6 3 2005 Market A Access	2574	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 200	. Registrar's Signatu	ure .	- y [NOSV]][W 1110	~ 1 /3 1	

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	Physici /Medio		Maria Zaryk		0,2005 12:25 a ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			234 S. CHESTER STREET	BALTIMORE	N/A
	Funeral Director		5. Social Security Number 214-44-4452 Usual Residence of Decedent	. Months Days Hours Min. (Month, Day	7, 1929 UKRAINE
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	Mary f sh	jo	MD N/A Bal	timore	13X∏Yes 2 ☐ No
	1 the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	3a o	ū	234 S. Chester Street	21231	U.S.A.
	deat ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9	or He	E	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 1 ☐ Yes (ive)	1 Yes X No Specify:	
8	72 hours after death with the Maryland natural; or items 23a or 28e-f show deat Examilium must burnatified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	TOTOS ECINO Specilly.	Specify: White
21215-0036	be filed within 72 hours after death with the Marylan ital Hygtiene. Id other then "natural; or items 23a or 28e-f show of other then "natural; or its Madical Examination in the Madical Examination."	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
121	vithin ne. ben	dm	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
	filed within Hygiene. wher then "		1.2 17. Father's Name (First, Middle, Last)	Housewife 18. Mother's Name (First, Middle,	Domestic
anc	be for	Be	Powlo Bylo	Sophia Kowba	
Ž	S should be filed within and Mental Hygiene. Is marked other then aumatic event, ILE M	2	-	9b. Mailing Address (Street and Number or Rural Route Numbe.	
Maryland			Andrew Zaryk/Husband	234 S. Chester St. Balti	
	ges 1 and t of Health If item 27 or other to		20a. Method of Disposition 20b. Place	of Disposition (Name of Date	20c. Location - City or Town, State
Baltimore,	0 0		Burial 2 Cremation 3 Removal from State	ntery, crematory or other place) Michael Cemetery 1/22/05	
臣	it. P		. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	
Ba	permit. Pag Department Importent; I any injury o			7 - 1 1 0 7 1 Tm-	Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	1901 Eastern Ave. Ba	Lto, Md 21231
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
	Physician /Medical	i	disease or condition resulting in death) a. Due to (or as a consequence)	TAL CANCER	YEAR
	Examiner		Due to (or as a consequenc	39 or).	4 MONTE
Н		e	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury	pe of):	
	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.		
o,	exection and and rial-tr		resulting in death) Last Due to (or as a consequence	pe of):	
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	edicai	d		
9	ng ph		IF FEMALE:		
Вох	attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy	ath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
	at the dea by the al tached fo	sici	1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	5 ☐ Other (specify)	Month Day Year
P.0	d by I	Phy		Single words bin as a superior Book 1	bacco use contribute to the cause of death?
Ś,	The law requires that the te has been signed by th age 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	
ecords,	w requir been s should	Completed			33 2200 0 7 100000 4 1000000
ec	e law has b	nple		24a. Was a autops	sy prior to completion of cause of
<u>R</u>		Co		perform 1 Tes	med? death?
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only or	10)
of	phys this al dii	2	1 Inpatient 2 EPV		ence 6 Other (Specify)
		on	1 Natural 5 Pending (Month, Day Year)	b. Time of	ow injury occurred
isi		icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,		treet and Number or Rural Route Number,
Division	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town	n, State)
_	Hospitel	C	29a. Certifier 1 Sertifying Physician: To the best of my knowled	dge, death occurred at the time, date and place, and due to the c	ause(s) and manner as stated.
	e Ho: 24 h e Fui	edical	(Check only one) Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred at the time, d	ate and place, and due to the cause(s)
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
	1		> C/ Derbti	D29373	1/21/05
	b		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	
				FALLS RD, SUITE 200 LUTHER	VILLES MD 21093
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Scerli	

DHMH 17 Rev 1/2001

ORIGINAL

4			1 - For State Registrar	State of		d / Depa	artmer	t of H		and M	ental Hy		005	017	48
	Discontinu		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea		Voor	3. Time of	Death
	Physici /Medic			OUB							January	Day 03	2005	9:29	РM
	Examin		4a. Facility Name (If not institution, give		ber)				Location o		-	4c. (County of Dea	th	
			Holy Cross Hosp						Spri				ontgom		
	Funeral Director		379.30.1440	9x 7	64 Age (In yrs. I	ast birthday) Yrs.	Months Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Oct. 0	h y, Ye <i>ar)</i> 15 , 19	9. Bill 40 Pa1	thplace (State o ountry) Rama estine	illah
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ty Limite
	danyi f sho	৳	Maryland Montgom	erv		ilver		10						1X Yes	
	the /	ect	10e. Street and Number				10f. Zip					10a Citiz	en of What C	ountry?	
	With 38 or	0	12618 Eastbourne	Drive				0904					S.A.	outiny.	
	ns 2	era	11. Marital Status	12. Was Deced		S. 13.			spanic Orio	gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Am	erican Indian.	
9	after or ita	by Funeral Director	1 ☐ Never Married 2 ☒ Married	Armed Ford	No No					i, Puerto I	Rican, etc.)		Black, Whi		
8	72 hours after death with the Maryland natural', or itame 23a or 28a-f show disal Exandra must be undiffed at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 🗌 Yes	21XINo	Specify:				Specify: Wh	ite	
5	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece	dent's Usu kind of wa	al Occupa	ation Jurina most	t of workii	na	16b, Kir	d of Business	/Industry	
21	within ene.	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)			se retired	luring most)		.3	** .			
2	be filed within 72 hours after death with the Marylan hat Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Madical Examinating the collided at		12th 17. Father's Name (First, Middle, Last)			Wa	aiter		40 11.0	1. 54:	(F)		el Ser	vices	
anc	ntal H	Be									(First, Middle,		Sumame)		
ž	should be on the should be on the should be on the short and the short a	²	Ishaq Sliman A 19a. Informant's Name/Relationship (7)			40h 14-16		(0)		eefe!					
Maryland 21215-0036	- 6 6 5		Judy L. Ayoub/Wi								Route Number, Silve				
	1 and 2 Health: am 27 I		20a. Method of Disposition		20b. P	lace of Dispo					ate		ation - City or		
Baltimore,	ages in of control		1 Burial 2 Cremation 3 C							11/07	/2005				
Ė	permit. Pag Department Important: any injury once.	1	4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen		Gai	22	Name ar	n Ce	me . U)1/U/	/2005	sitve	r Spri	ng, Mar	yland
Ba	permit Depar impor any in	; ;	A	P	tai	H	INES-	RINA	LDI F	UNER	AL HOME	I, IN	IC.	ng, MD	00001
			23a. Part1. Enter the disease, or comp	olications that ca	used the death	n. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory ar	rest,	r Spri	Approximat	ө
	Physician	,, ,	Immediate Cause (Final	one cause on ea	ch line.									Interval Bet Onset and I	ween Death
	/Medical		disease or con lition resulting in death)	u	emic Ca		yopat	ny							
	Examiner			Conc	estive	•	Fail	ure							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		r as a consequ										
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Aort	ic & Mi	tral V	Valve	Rep.	lac e m	ent					
, 0,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (o	r as a consequ	uence of);									
8760,	ate b	dicai	•	d											
9	death certifics e attending pt id for use as th	Med	IF FEMALE:	00- 16						-					
Вох	attenc attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 🗌 Fetal	death 3	Ectopic p					2	3d. Date of de Month		ear
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov	nt at time of de vn	eath 5L	Other (sp	өсту)						,	
<u>α</u>	law requires that the de as been signed by the z 2 should be detached t		Part II. Dther significant conditions of	ontributing to dea	ath but not resu	ulting in the u	nderlvina d	ause give	en in Part I.		23e. Did to	obacco us	se contribute t	o the cause of d	eath?
Records,	uires tha signed Id be del	d by					, ,							robably 4 🔼	
cor	w require been si should {	Completed									24a. Was	20	24h Woro o	utanau findinan	available
Re	9 4 8	dmo									autop		prior to death?	utopsy findings completion of c	ause of
Vital	ician: The certificate rector, pay	Ö	25. Was case referred to medical						00 81	-/	1X Yes		1 🔀 Yes	2 □ No	
>	Phyaician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1X In	patient 2	ER/Outpatier	1 3 T D	Othe	ar.		<i>(Check only o</i> ne 5⊟Resid		DOthor (Co.	noife)	
of		n: T	27. Manner of Death	28a. Date of (Month		28b. Time of		28c. Injury Work			28d. Describe h			city)	
0	.⊑ . ₹ 5	atio	1 Accident 5 Pending 2 Accident investigation		, Day rear)	Injury	м		res 2 🗆 l	No					
Division		iffic	3 Suicide 6 Could not be determined	286. Place 0	of Injury - At ho	me, farm, str	eet, factor	, office		2	28f. Location (S City or Tou	Street and	Number or R	ural Route Num	ber,
Ö	s afte	Certification:		Dailotti	y, etc. (opecity	'/					Ony or row	m, State)			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 ☒ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the taininer: On the bas	sis of examinat	wledge, deatl tion and/or in	n occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a th occurre	and due to the dead at the time, d	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2. To the I complet	Z	29b. Signature and title of certifier	1	_			. License				29d. Date	signed (Mon	th, Day, Year)	
}	5		Kh	aft i	$m \cdot D$	•	2	100.	5600	63		1/5	1/05	_	
			30. Name and address of person who Kanwaljit Nagi,				Print)				pring.	Marv	land 2	0910	
.3	Sta		31. Date filed (Month, Day, Year) JAN 0 7 2								- 07				
	, . Registi	rar	JAN 072	UUD	du 1	S M	The same								

			For State Registrar	State of Maryla	and / Department of Hea Certificate of De	•	giene 005	01749
Ħ	Physicia		Decedent's Name (First, Middle, La.	st) /	P	2. Date of De Month		3. Time of Death
	/Medic	ai	Kobert (=, Lee	DUCKNER	01	4c. County of Deat	10:30 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Los	Cation of Death	County of Death	5-4
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yr	rs. last birthday) If Under 1 Year If	Under 24 Hrs. 8. Date of Bi	rth ay, Year) 9. Birth Co	hplace (State or Foreign
			Usual Residence of Decedent			12-5	- 17 3 /	
	anylan show	_	10a. State 10b. County	100.0	City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	10e. Street and Number	rset I	101. Zip Code		10g. Citizen of What Co	
	3a or	I Di	29111 Sm	He Blud	218	53	11.5.	A,
	r deatl	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispa If Yes, specify Cuban, N	inic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)	o- 14. Race - Ame Black, White	
036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "neturel", or items 23a or 28e-f show event, the Madrel Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1□Yes 2DNo S	Specify:	Specify: R	lack
21215-0036	c * 33	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NQT use retired)	n ng most of working	16b. Kind of Business	Industry
212	should be filed within nd Mental Hygiene. marked other then "imetic event, it is Mental then "imetic event, it is Mental then "imetic event, it is the Mental the Men	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Bus driver		Somo=se-	+ Comment
	S should be filed withing and Mental Hygiene. Is marked other then surmetic event, Ithe Mental Ithe Me	Be C	17. Father's Name (First, Middle, Last,	1		. Mother's Name (First, Middle	, Maiden Sumame)	419
Maryland	should bend Ment and Ment a marked umetic o	٦	Robert L	ce Buck		DINCIE (OUNCIL	Zin Codo)
Ma			19a. Informant's Name/Relationship (15/CA 10- (11)	19b. Mailing Address (Street and	plud Pair	ner, City or Town, State, 2	nd 21852
re,	es 1 and 2 of Health of Hem 27 i f Item 27 i		20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
altimore,	Pa nen ant:		1 ☐ Burial 2 🐧 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) (',	anital Cremeter	1-13-05	Dower	De.
Balt	permit. Pag Department Importent: I any injury o		21. Signatur of Fureral Service Licen	1800	22. Name and Address of	th functal	Home Saliching A	14.21811
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not enter the mode of dying, s	uch as cardiac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Unc	Cancer			Opset and Death
	/Medical- Examiner		resulting in death)	Due to (or as a cons	sequence of):			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	sequence of):			
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of/:			
8760,	cate be executed physician and s the burial-transit	dical E		d				
9	ertifica ing ph e as th	Med	IF FEMALE:					
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3 □Ectopic pregnancy		23d. Date of deli Month	ivery Day Year
0.	t the d by the tached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown				
ds, P	The law requires that the death certifi ste has been signed by the attending I bage 2 should be detached for use as	by	Part II. Other significent conditions of	ontributing to death but not r	resulting in the underlying cause given in		tobacco use contribute to	o the cause of death? obably 4 Dunknown
Records,	aw requir s been si 2 should I	Completed				24a. Was	s an 24b. Were au	itopsy findings available completion of cause of
I Re		Com				perf	formed? death?	2□ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	3. Place of Death (Check only		
of	Phys r this ral dii	To :	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	DENOGIPATION 30 DOX		idence 6 Other (Specification)	oify)
ion	Attending I ar death. ector: After by the funer	atior	1 Natural 5 ☐ Pending investigation) Injury Work? M 1 ☐ Yes	2 □ No		
Division	or Attendiater death. I Director: A din by the fu	ertific	3 Suicide 6 Could not be determined		at home, farm, street, factory, office ecify)		(Street and Number or Ru own, State)	ıral Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification:	29a. Certifier Certifying Pl	hysician: To the best of my k miner: On the basis of exam and manner stated.	knowledge, death occurred at the time, ination and/or investigation, in my opinion	date and place, and due to the on, death occurred at the time	cause(s) and manner as , date and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b Signature and title of certifier	Robert A. Col	Ker D.O. 29c. License nu	umber	29d. Date signed (Month	h, Day, Year)
			1 Cul		Hoo	56197	1/10/0	5
H	.5		30. Name and address of person who			6815 am		
:-	Sta Regist		31. Date filed (Month, Day, Year)	32. registrar's Sig	gnature Species			

Funeral Director Social Security Number S	9. Birthplace (State or Foreign Country) 1920 Maryland 10d. Inside City Limits 1 Yes 2 No Notitizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry nufacture Furniture in Sumame) Hollinger or Town, State, Zip Code) EXAS 75604 Location - City or Town, State
Waryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. City 8507 Mapleville Road 21713 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1/2 yes 2 No 1/2	10d. Inside City Limits 1 □ Yes 2 No No No No No No No No No No
10e. Street and Number 10f. Zip Code 21713 10f.	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry nufacture Furniture n Sumame) Hollinger or Town, State, Zip Code) exas 75604 Location - City or Town, State
The second of Disposition 1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Last) 1. Father's Name (First, Middle, Maider 1. Father's Name	n Sumame) Hollinger or Town, State, Zip Code) EXAS 75604 Location - City or Town, State
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Rural Route Number, City of Rural Route Number, City of Rural Route Number of Rural Route Number, City of Rural Route Number, City of Rural Route Number of Rural Route Number, City of Rural Route Number of Rural Route Number, City of Rural Route Number of Rural Route Number, City of Rural Route Number of Rural Route Number, City of Rural Route Number of Rural Route Number, City of Rural Route Number of R	coation - City or Town, State
20c. Le 20d. Method of Disposition 1	
21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Hom Andrew K. Coffman Funeral Hom 40 East Antietam Street, Hage 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Physician / Medical Examiner Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	107
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Unknown 1 Unknow	23d. Date of delivery Month Day Year
νατ ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	24b. Were autopsy findings available
performed? 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Hospital: Other: Oth	prior to completion of cause of death? o 1 ☐ Yes 2 ☐ No
27. Manner of Death 1 Shatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Shatural 28d. Describe how injury (Month, Day Year) 3 Suicide 3 Suicide 4 Homicide 28d. Describe how injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Could not be determined	ury occurred Ind Number or Rural Route Number,
29a. Certifier (Check only (Ch	s) and manner as stated. Id place, and due to the cause(s)
one) and manner stated. 29c. License number 29d. Da 0 5 2 3 2 3	ate signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid M. Waseem M.D. 1125 Opal Court, Hagerstown, No. 1. Date filed (Month. Pay Year) 31. Date filed (Month. Pay Year) 32. Refistrar's Signature	Maryland 21740

Buchanan

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		1	For State Registrar	State of M	arylan	•	irtment of H <i>tificate of L</i>			giene Reg. No.	2005	01752
Dhyoi	oion		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Dav	y Year	3. Time of Death
Physic /Med			HELEN	BELI					JANUAR	Y 5,	2005	5:15 A M
Exam	ine	1	la. Facility Name (If not institution, give				4b. City, Town, or POTOMAC	Location of Death		1	County of Deat	
Francis			MANOR CARE OF 1 5. Social Security Number 6. Secur		je (In yrs. l	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		hplace (State or Foreign
Funera Directo				M 2√√2 F	80	Yrs.	Months Days	Hours Min.	Sept. 1	3, Year)	.924 Mar	yland
P .		-	Usual Residence of Decedent		100 City	, Town or Lo	cation					10d. Inside City Limits
aryla shov	1		10a. State 10b. County				Cation					1, Yes 2 No
the N	Director	5	Maryland Montgomer 10e. Street and Number	`У	Poto	mac	10f. Zip Code			10g. Citi	izen of What Co	Λ
3e or			9613 Pinkney Court				20854			U.	S. A.	
ine, Wall ylail of LELICOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCO	Tion	-		12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
or Ite	ü	2	1 Never Married 2 Married	1 ☐ Yes 2 📉 If Yes, Give			I∐Yes 2∭ No	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify:	
hours turel,	P. P.		3 ☐ Awidowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:		16a Decer	lent's Usual Occupa	ation		16b K	ind of Business	WHITE
in 72 in 72	patalamo	- 10	(Specify only highest grad	e completed)	E.\	(Give	kind of work done o	furing most of work	ing	100.11		
d with diene.	8	5	Elementary/Secondary (0-12) 12 Years	College (1-4or	3+)	Sa1	es			Li	quor	
al Hyg		D	17. Father's Name (First, Middle, Last)					18. Mother's Name			Sumame)	
y and bould be Ment arked		2	Leon VanGrack					Jesse Ho				
VICION VI			19a. Informant's Name/Relationship (Ty Steve J. Bellman -				ng Address (Street a					
es 1 and of Health fitem 27		3	20a. Method of Disposition	. 2011	20b. P	lace of Dispo	Pickney (sition (Name of	!	Date		cation - City or	
Pages tment of Henri If it			1 Burial 2 Cremation 3 XF 4 □ Donation 5 □ Other (Specify)	Removal from State			natory or other place d Mem. Ga		/05	Fall	s Churc	h, Virginia
3 1 E E E E	9	-	21. Signature of Funeral Service Licens	ee 1		22	Name and Addres	s of Facility	AEMODT A	т си	ADELC	TNC
g gg E g	OUCE		Donald C.	Xtota	Tome	11 A	70 ROCKVI	PLE LIKE	, KUCKV	TLPE	, MD 2	U852
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause ne cause on each l	d the death ine.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician	_	1	Immediate Cause (Final disease or condition	a. PNEUMON	IA							Onset and Death
/Medica Examine	_	1	resulting in death)	Due to (or as								2 MONTHIA
		<u>.</u>	Sequentially list conditions,	Due to for as			CIDENT					3 MONTHS
uted d ansit			cause. Enter Underlying Cause (Disease or injury that initiated events									
exect an and rial-tra	5	E X	resulting in death) Last	Due to (or as	a consequ	uence of):						
not out, licate be executed physician and s the burial-transit	100	dicai		d								
± 50 a		D	IF FEMALE:	220 16 1100 0110000				-221h				
us, r.o. box or ires that the death certific signed by the attending of d be detached for use as	100	Physicianim	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
	1	1) SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	it till or di							
taw requires that the as been signed by the 2 should be detached.		Dy Pr	Part II. Other significant conditions co	ntributing to death	but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco	use contribute to	the cause of death?
w requires been sign should be									1 🗆	Yes 2	Mo 3□Pi	robably 4 Unknown
aw reas be to sho	1	biet							24a. Was			utopsy findings available completion of cause of
The The ate h		Сотріете							perfo 1 ☐ Yes	ormed? 2 🔯 Na	death? 1 ☐ Yes	2 □ No
VICAL P ician: Th certificate rector, pag		De	25. Was case referred to medical examiner?	Janaital.			Oth	26. Place of Deat			V=17-17	
Physi Physi this c	- 12	0	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 ☐ Inpat 28a. Date of Inj	-	ER/Outpatien 28b. Time of		er: 4 🛛 Nursing Ho	me 5 ☐ Resi 28d. Describe			cify)
SION (tending leath.	1	Hon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	Wor	k? Yes 2 □ No	200. 0000.100		.,	
Atten Atten r deat octor:		IIca	3 Suicide 6 Could not be	28e. Place of Ir	njury - At ho	ome, farm, str	reet, factory, office		28f. Location (City or To	Street ar	nd Number or R	ural Route Number,
s after		Certification:	4 Homicide	building, e	tc. (Specif	γ)			City of 10	WII, State		25 NO.
To the Hospitel or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		dical	29a. Certifier 1X Certifying Phy (Check only one) 1 Medical Exam		of examina							
o the vithin ? o the omple	110	Me	29b. Signature and title of contier	7 /	-/		29c. Licens	e number		29d. Da	ite signed (Moni	th, Day, Year)
1			1 150	29/51	5		D3	6797		JANU	UARY 6,	2005
6			30. Name and address of person who c				Print)					
			ALLAN R. SHEFF, M					OOA BET	HESDA,	MARY	LAND 2	0817
Regi:	State		31. Date filed (Month, Day, Year) JAN 1 0 20	05 32 Regis	trar's Signa	the Ap	ale					
negi	211 E		JAN 1 U Zu	US JUGA		1						

		For State Registrar	State	of Marylan	-	artmen rtificat					iene	005	01753
0		1. Decedent's Name (First, Middle	, Last)							2. Date of Deat Month		Year	3. Time of Death
Physici /Medic		Virginia	Marsh		Batka					January		2005	12:05 ^a M
Examir	ıer	4a. Facility Name (If not institution Holy Cross Rel	-		Ctr			Locetion o				inty of Death	-
		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under		If Under		8 Date of Birth		tgomer	
Funeral Director		213-40-7298	1 □ M 2X□ F	88	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, Nov 22	Year) 1916	Coul Kar	place (State or Foreign ntry) 1Sas
P .		Usual Residence of Decedent		10.00	- .								
shov	5	10a. State 10b. County	ce George		y, Town or Lo College								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the N 28a-f	Directo	Maryland Prin 10e. Street and Number	ce George	5 0	orrege	10f. Zip			<u> </u>	1	Og. Citizen	of What Cou	
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or items 23a or 28a-f show ant, the Modical Exercity or visit be modified at		7325 Radclif	fe Drive				740				US		···· ',
death	Funeral	11. Marital Status	12. Was Dec	pedent Ever in U.	.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
or lite		1 Never Married 2 Marri	ied 1 ☐ Yes If Yes, G	2 X No	1	1 ☐ Yes		Specify:		mouri, oto.)		ecify: Whi	
5-0036 72 hours at natural, or died Exert	ed by	3♣ Widowed 4 Divorced 15. Decedent	Year or I	Dates:	16a. Dece	dont's Heus	al Occupa	ition				f Business/In	ductar
CL 2	plet	(Specify only highes	t grade completed		(Give	kind of wor DO NOT us	rk done d	luring most	t of workir	ng	iob. Kind c	ii Dusiriessyiii	dustry
d with giene	Completed	Elementary/Secondary (0-12)	5-	(1-4or 5+) -	Tea	cher					Ed	ucatio	on
e e = 0 \$	Be	17. Father's Name (First, Middle,	•							(First, Middle, I	Maiden Sun	пате)	
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	2	Virgil P. M			105 14-10		(2)			Foster	0° T		
Baltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enones.		19a. Informant's Name/Relations! Mary B. Depenb		ghter		-				Route Number Silve			
re, s 1 an f Heal item 2 other	1 19	20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. P	Place of Dispo semetery, crer	sition (Nan	ne of	Ţ	D	ate		on - City or To	
altimore, mit. Pages 1 a partment of Hee portant: If item y injury or othe		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			ington N					nary 24 005 A	rlino	ton J	/irginia
calti mmit. spartm sports ny inju		21. Signature of Funeral Service			22 F	Name an	d Addres	s of Facilit		Funeral			IIgIIII
n && = = = =		Illie E	77000	در		500 U	nive	rsity	Blv	d, W, S.	llver		g, Md 20901
Wint.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
Physician /Medical	2 1	Immediate Cause (Final disease or condition resulting in death)	a	in Cance									6 Months
Examiner			Due to	(or as a conseq	uence of):								
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a conseq	uence of):								
cuted nd ransit	Examiner	that initiated events	o										
60, the executed sician and burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	uence of):								
the the	dlcal		d										
BOX 61 Bath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		atcome of pregna							23d.	Date of delive	erv
death death death death	Iclai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	birth 2 ☐ Feta nant at time of d]Ectopic pr] Other (sp						Month	Day Year
P.O.	hys	9 Unknown	9□ Unkı	nown									
_ ~ ~ ~	by	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying c	ause give	n in Part I.					he cause of death?
ecords, law requires t as been signe	eted									-			pably 4 □Unknown
o - 0	Completed									24a. Was autops perform	/	b. Were auto prior to co death?	psy findings available mpletion of cause of
VITAL F	e Co	25. Was case referred to medical						OC Disease	-4 D4h	1 ☐ Yes 2	™ No		2 No
(9)	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	it 3 DC	A Othe			(Check only on ne 5 ☐ Reside		Other (Specif	(v)
Vision of VIta Attending Physiclen: or death. ector: After this certific by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date		28b. Time of Injury		8c. Injury Work			28d. Describe ho			,,
ision ktendir death. ctor: Af	catlo	2 ☐ Accident investig	gation		,,	М		/es 2 □ I	No				
DIVISION OF I or Attending Phy after death. Director: After this I in by the funeral d	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Plac	e of Injury - At he ling, etc. (Specif		eet, factory	, office		2	28f. Location (St. City or Town		ımber or Rura	Al Route Number,
spital ours a neral i		29a. Certifier 1 Certifyin	g Physician: To th	e best of my kno	wledge death	n occurred	at the tim	e date an	d place, a	and due to the ca	use(s) and	manner as s	tated
To the Hospital or within 24 hours after To the Funeral Direction completely filled in 1	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ition and/or in	vestigation	in my op	oinion, dea	th occurre	ed at the time, da	ite and plac	ce, and due to	the cause(s)
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	11 -	_	The second	290	. License			25		ned (Month,	
12) fart	VV			-)4	32	37		Jar	uary (6, 2005
100		30. Name and address of person Paul Armstror				,	Driv	ve, #	102,	Laurel	MD 2	20707	
Sta Regist		31. Date filed (Month, Day, Year) JAN 0 7	2005	egistrar's Signa	ture A	ale							

DHMH 17 Rev 1/2001

			1 - State of Mar		artment of He			ege() (5 01754
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day	3. Time of Death
	/Medic		HELEN SYLVIA BEAN				January	03 20	005 1:01 P M
	Examir	ier	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			4c. County of	
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age ('In yrs. last birthday)	If Under 1 Year	Spring If Under 24 Hrs.	9 Date of Righ	_	gomery 9. Birthplace (State or Foreign
М	Funeral Director			9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 18	1925 n	Country) Maryland
	7		Usual Residence of Decedent		11_			, 1	nal y Land
	how			Oc. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma Sa-f s	cto	Maryland Montgomery	Silver S	Spring				1 X Yes 2 □ No
	or 24	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	nat Country?
	s 23a	by Funeral Director	508 Valley Brook Drive		20904	i- O-i-i-2 (S	-it. Van an Na	U.S.A.	Amaiaan Indian
	Item	Į.	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Ves 2 ☑ No		Was Decedent of His If Yes, specify Cuban	n, Mexican, Puerto	Rican, etc.)		- American Indian, , White, etc.
936	al', or	by	3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 2 🔼 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show hs Madigal Examinar must be notified at	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupat	tion	10	6b. Kind of Bus	iness/Industry
21	thin 7	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done du DO NOT use retired)			77.1.	1
2	ygien ygien ygien t, th		12th	Exe	cutive Sec			Vitro L	
Maryland	be fi	Be	17. Father's Name (First, Middle, Last) Earl H. Robey			18. Mother's Name Helen E.	lizabeth		
Σ	houtd d Mei marke matic	10	19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Address (Street ar				
S	d2s than trau		Robert F. Bean/Son					•	, MD 20904
ā,	Heal Heal tam 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of				ity or Town, State
OL	ages and of the same of the sa		1 Burial 2 □ Cremation 3 □ Removal from State Graph of the Control of the Con	Union Ce	matory`or other place meterv		3/2005 Bu	rtonevi	llle, Maryland
Baltimore,	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importants If item 27 Is marked other than "natural", or Items 23a or 28a-f show any nigry or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens		2. Name and Address INES-RINA	of Facility	,, 2005 B		riic, naryiana
m	Departition of the service of the se	Ш	Naman A Vecant	- 1 I	INES-KINA 1800 New H	LDI FUNER Hampshire	Ave. Si	INC. lver Sn	ring, MD 20904
			23a. Part1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line.	e death. Do not ent	ter the mode of dying	such as cardiac o	r respiratory arres	it,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition Sepsis						Onset and Death Days
	/Medical		resulting in death)	consequence of):					Days
	Examiner		Sequentially list conditions. Multiorg	an Failur	e				Days
	pa ji	ine	cause. Enter Underlying	consequence of):					
	and P-tran	Examiner	that initiated events	testinal :	Bleeding				Days
8760,	ate be executed thysician and the burial-transit	alE	· ·		Infarction	,			Days
687		edical	d	Jour ara	Intarction				
Вох	leath certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of		7			23d. Date	of delivery
	The law requires that the death certific ate has been signed by the attending p cage 2 should be detached for use as	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			Mont	h Day Year
P.O.	by the	hys	9 ☐ Unknown						
	signed of be det	by P	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause giver	n in Part I.	23e. Did toba		oute to the cause of death?
ord	w require been si should I	ted					1 🗆 Yes	2 □ No 3	Probably 4 🖺 Unknown
Records,	law r as be	Completed					24a. Was an autopsy	pri	ere autopsy findings available or to completion of cause of
E .		Com					performe 1 ☐ Yes 2	ed? de	ath? ☐Yes 2☐ No
of Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?			26. Place of Death			
of	phys this al dii	2	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient		nt 3□ DOA	4 Nursing Hor			
no On	a fe	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day)	(eer) 28b. Time o	Work'	at ? ′es 2 □ No	28d. Describe how	njury occurred	3
Division	Attanding or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	/ - At home, farm, str		_	28f Location (Stre	net and Number	or Rural Route Number,
Dί	after Direct	Certification:	4 Homicide determined 200. Flace of injury building, etc.	(Specify)	root, radiory, ornoo		City or Town,	State)	
	spita nours neral		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, deat	h occurred at the time	e, date and place,	and due to the cau	rse(s) and man	ner as stated.
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of early and manner state	xamination and/or in d.	vestigation, in my opi	inion, death occurr	ed at the time, dat	e and place, an	d due to the cause(s)
	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Ž	29b. Signature and title of certifier		29c. License		290	d. Date signed	(Month, Day, Year)
			A. Nawaz		D500	48+		1 - 4	-05
	7		30. Name and address of person who completed cause of dea		and the same of th		Maria tre		0.000
			31. Date filed (Month, Day, Year) 32. Degistrar	30 X 838	519 9	AITHE	15801	-9	.0 -0883
	Sta Regist		31. Date filed (Month, Day, Year) 32. Segistrar.	s Signature	sell!				

		. 1000	State of			artment of H			•		3.010.		
		1 - For State Registrar	Otate of	war y lar		tificate of			, ,	Reg. No.	005	017	155
		Decedent's Name (First, Middle,)	Last)						2. Date of Dea	ath		3. Time of	Death
Physic /Med		Charlotte S. E	Blevins						Month Januar	Day У 5, 2	Year 2005	8:09	a M
Exami		4a. Fecility Name (If not institution, g	give street and nun	nber)		4b. City, Town, o	r Location	of Death		4c. Cou	inty of Death		
		Holy Cross Ho		7 800 //0 1100	last hirthday)	Silver If Under 1 Year			9 Date of Bird		ontgon		- C:
Funeral Director		5. Social Security Number 6 216-10-9532	1 M 2 TF	7. Age (In yrs.	86 Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day May 3,	y, Yea <i>r</i>)		place (State o ntry) ISY l van	
		Usual Residence of Decedent							nay 5,	1310	Tem	isy I vai.	ira
arylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside Ci 1 ☐ Yes	-
he Mi	ecto		omery		Silver					10- Citi	-(14/1		2 10
with t	Ö	10e. Street and Number 3114 Gracefiel	d Road	Δn+ 3	11	10f. Zip Code 2090	1			10g. Citizen USA		ntr y r	
death with the Maryland ime 23a or 28a-f show	by Funeral Director	11. Marital Status	12. Was Dece	dent Ever in L		Was Decedent of H		igin? (Spe	cify Yes or No-		Race - Ameri		
after or Ite	Ē	1 ☐ Never Married 2 ☐ MMarried	Armed For 1 Tes If Yes, Giv	2 X No		fYes, specify Cuba 1 □ Yes 2 Ho	an, Mexicai Specify:		tican, etc.)		Black, White. ecify: Wh:	ite	
2-UU30 72 hours af natural, or disal Exam	d b	3 Widowed 4 Divorced	Year or Da	ites:	. 1				,				
n 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during mos d)	st of workir	ng	16b. Kind o	f Business/In	idustry	
d within giene.	E O	Elementary/Secondary (0-12)	College (1: 5+	-4or 5+)	1	obiologi				Cano	er Res	search	
al Hyg	BeC	17. Father's Name (First, Middle, La	ist)				18. Moth	er's Name	(First, Middle,	Maiden Sun	name)		
Viand Suld be file Mental Hy arked oth attic event	10	Ira Shaull			_		Cha	rlott	e Schn	epfe			
Mar d 2 sho th and th and traum		19a. Informant's Name/Relationship		_		ng Address (Street						21	0904
Health Health		John P. Blevins 20a. Method of Disposition	/ Husban			4 Gracef		D	ate		Sprin		
ages int of t: If It		1 Burial 2 Cremation 3 '4 Donation 5 Other (Spe		State		sition (Name of natory or other plac an Cremato		Janua	_				
DESIGNATION FOR MAINTIGHT ALL IN-UOSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or lieme 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and the profiled at once.		21. Signature of Puneral Service Lie		1		Name and Addre						Virgin	nia
D age of		1 (inchen	Sol Col	le		CO Unive						ng, MD	20901
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that can't use on e	aused the dea ach line.	th. Do not ent	er the mode of dyir	ng, such as	s cardiac o	r respiratory ar	rest,	:	Approximat Interval Bet	ween
Physician	_	Immediate Cause (Final disease or condition	_a Seps	sis								Onset and I	Jeath
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):								
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	or as a conse	quence of):						_		
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
ate be executed hysicien and the burial-transit		resulting in death) Last		or as a conse	quence of):								
. BOX b8/bU, death certificate be executed e attending physicien and id for use as the burial-transit	dical		d								-		
cords, P.O. Box 68/ wrequires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, out	come of preon	ancv					224	Date of delive	00/	-
Bath aften	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	irth 2 ☐ Fet ant at time of	al death 3	Ectopic pregnancy Other (specify)	4				Month	*	'ear
cy the dached	hysl	9 Unknown	9□ Unkno	wn									
ords, r.C requires that the leen signed by th hould be detache	by P	Part II. Other significant condition				, , ,	en in Part I	l.	23e. Did to	obacco use c	ontribute to t	he cause of d	eath?
w requires been sign		Alzheimer's Di	sease , (Congest	cive He	art Fai	lure		1 🗆 Y	′es 2□No	3 ☐ Prot	bably 4 X U	Inknown
N a a co	ompleted								24a. Was autop	sy	prior to co	ppsy findings a impletion of c	available ause of
a te	O								perfor	2% No	death? 1 🗌 Yes	2 No	
Or VIKAL Physicien: The This certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	anationt 2E	ER/Outpatier	t 3C DOA Oth			(Check only or ne 5 ☐ Resid		Othor (Cossi	6.)	
OR OT VITAL iding Physicien: th. After this certifice funeral director, p	F	27. Manner of Death		of Injury h, Day Year)	28b. Time o		y at		8d. Describe h			'Y)	
ath. pr: Aft	atio	1 Natural 5 Pending 2 Accident investiga	tion	n, Day rear)	injury		Yes 2]No					
DIVISION or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place	of Injury - At h	nome, farm, str ify)	eet, factory, office		2	8f. Location (S City or Tow	Street and Nu n. State)	mber or Rura	al Route Num	ber,
pltel c		29a, Certifier 1「X Certifying	Dhusisian Tartha	hant of my ten	autodao dosti	h and at the ti-			and along to the co			Antoni	
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)	Physician: To the kaminer: On the ba and mann	asis of examin	ation and/or in	vestigation, in my o	pinion, dea	ath occurre	ed at the time, o	date and plac	manner as s ce, and due to	o the cause(s)
To the within To the compl	Me	29b. Signatule and title of certifier				29c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)	
		Myma	a Mr			33	2332			Jan	uary 6	, 2005	5
S		30. Name and address of person w		,			0.00						
	toto	Suresh K. Gup					220,	Silve	er Spri	ng, MI	2090	2	
S Regis	tate trar	JAN 07	2005	ر میں	F Ap	240							

			, 101	eartment of Health and Me	•	•	01756
-	,		Registrar	ertificate of Death	Reg. I	No.	01700
_ 8	Physici	an	1. Decedent's Name (First, Middle, Last) Dorothy E. Buete			Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	5 2005 4c. County of Death	1012 A ^M
	Examin	E	Memorial Hospital	Easton		Talbot	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Date of Birth (Month, Day, Yea Feb. 25, 1	9. Bírth Cou	place (State or Foreign ntry)
	Director		218-12-3218 1 M 2 F 93 Yrs. Usual Residence of Decedent		Feb. 25, 19	911 Mar	yland
13	yland		10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
oth	e Marial	ctor	Maryland Queen Anne's Centrevi	.lle			1 ☐ Yes 2 No
Dorothy	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Event and must be invilible at once.	Funeral Director	10e. Street and Number 630 Poplar School Road	10f. Zip Code 21617		Citizen of What Cou nited Sta	•
	ams a	mer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ameri Black, White,	
te 36	s afte	by FL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 X No Specify:	,	Specify:	White
9 6	Phour	ed b		edent's Usual Occupation	16b.	Kind of Business/In	
215	hin 72 an "na Me fil	plet	(Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)			,
21	ed wit ygjene yar tha t, Le	Completed	11	emaker		own home	
Buete Maryland 21215-0036	be fill had off	Be	17. Father's Name (First, Middle, Last) Charles Beyer	18. Mother's Name (A	First, Middle, Maid Blackbi		
Š	should of Mer marks maric	은		ling Address (Street and Number or Rural F			Code)
	nd 2 saith an 27 is r trau			Poplar School Rd. C			
Jre,	of Hear		20a. Method of Disposition 20b. Place of Disposition cemetery, or	amatory or other place)	1	Location - City or To	
Ë	Page menf ant: If		'4 Donation 5 Other (Specify)	coln Cemetery 1/10/		entwood, 1	
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Devold Brownedt	2. Name and Address of Facility Onald V. Borgwardt 400 Powder Mill Rd.	Funeral F Beltsvil	Home, P.A. Lle, Mary	land 20705
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r			Approximate Interval Between
	Physician	Ė	Immediate Cause (Final disease or condition resulting in death) a. Thoracoablom resulting in death)	ind knewysm			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	9			20000
1	No. 1 Edit	er	Sequentially list conditions, if any, leading to immediate b. Due to or as a consequence of):				years
	cuted nd ransif	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events				
760,	that the death certificate be executed ed by the attending physician and detached for use as the bunal-transif	Ex	resulting in death) Last Due to (or as a consequence of):				
6876	cate b	dical	d.				
9 X	certiffi Iding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	4-44		23d. Date of delive	an.
Вох	death e atter d for u	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 \[\subsection \text{Ves} 2 \subsection \text{No} \] 4 \[\subsection \text{Pregnant at time of death} \] 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	at the by the tache	hys	9 ☐ Unknown 9 ☐ Unknown				
Vital Records, F	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	ompleted by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to t 2 ☐ No 3 ☐ Prot	
000	s beer s shou	olete	Antic sterais Rhennelpia gettinis		24a. Was an	24b. Were auto	ppsy findings available
Re	sician: The law certificate has t irector, page 2 s	om			autopsy performed 1 Yes 2	death?	mpletion of cause of 2□ No
/ita	ysician: is certifica director, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (
of \	Physician: this certific ral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie			6 ☐Other (Specif	(y)
Lo	ng fter inei	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in	jury occurred	
Division of	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be		Location (Street	and Number or Rura	al Route Number,
Ö	s after safter al Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	1(0)	
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal 2 Medical Exeminer: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	\mathcal{L}		tame Jame ins	041339	1	15/2005	
	7		30. N. e and iddress of person who completed cause of death (Item 23a) (Type Jamus Hallms m (3D Love 10, Jr.) 31. Date filed (Month, Day, Year) 32. Figistrar's Signature	Print) RO STEVENSMILLE	, MO 2	1666	
• 5	Sta Registr		31. Date filed (Month, Day, Year) 17.N. 0.7. 2005	parti	1		-

o Physician /Medical

Examiner

Director

Be Completed by Funeral

2

Examiner

Be Completed by Physician/Medical

Medicai Certification; To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avent, the Medical Examination in the indilibed at once.

Baltimore, Maryland 21215-0036

Registrer			partment of Health and ertificate of Death	Reg	g. No. UUD	01/5/
Decedent's Name (First, Mid MAR	idie, Last) Y AGNES BRO	WN		2. Date of Death Month JANUARY	Day 2005	3. Time of Death 7:40 P M
4a. Fecility Name (If not institut	ion, give street and num	ber)	4b. City, Town, or Location of De-		4c. County of Dea	
UPPER CHESAPEA			BEL AIR // If Under 1 Year If Under 24 H	rc	HARF	
5. Social Security Number 254–38–4196	6. Sex 1 ☐ M ¾ ☐ F	7. Age (In yrs. last birthda) 76 Yrs.	Months Days Hours Mi		1928 G	rthplace (State or Foreign country) COrgia
Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town or L	Location			10d. Inside City Limits
Maryland	Harford	Edgew	rood			1 ☐ Yes 2X No
10e. Street and Number 1846 Gremp	ler Way		10f. Zip Code 21040	10	g. Citizen of What C USA	country?
11. Marital Status		dent Ever in U.S. 13	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	(Specify Yes or No-	14. Race - Am Black, Wh	
1 ☐ Never Married 2 ☐ M 3 【 Widowed 4 ☐ Divorc	arried 1 ☐ Yes	No No	1 ☐ Yes 🏋 No Specify:	atto ritoan, etc.,		slack
15. Deced	ent's Education hest grade completed)	16a. Dec	edent's Usual Occupation	rorkina 10	6b. Kind of Busines	s/Industry
Elementary/Secondary (0-12		4or 5+) life.	e kind of work done during most of w DO NOT use retired) Never Worked	o.n.ng		
8 17. Father's Name (First, Middle	(e, Last)			ame (First, Middle, Ma	aiden Sumame)	
Amos Combs,	Sr.		Maggie	e Lewis		
19a. Informant's Name/Relation	nship (Type, Print)	19b. Mai	ling Address (Street and Number or	Rural Route Number, (City or Town, State,	Zip Code)
Donald Brown /	son		entral Ave., Atla		lands, NJ	07716
20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		tate	ematory or other place)	111/05	oc. Location - City o	
21. Signature of Funeral Service	ce Licensee		22. Name and Address of Facility Lisa Scott Fune: 552 Lewis Street	ral Home, I	P.A.	·
shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequence of): TRIAL For as a consequence of):	NEBRAL VASCES IN HEART	WLAR AC	CCIPENT	Approximate Interval Bate Interval Bate Onset and Death STAYS
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live bi	nt at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	blivery Day Year
Part II. Other significant cond	itions contributing to de	ath but not resulting in the	underlying cause given in Part I.			to the cause of death?
END ST.	AGE R	ENAL P	AILURE	24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
				eath (Check only one)		
25. Was case referred to medi examiner?			ent 3 DOA Other: 4 Nursing	Home 5 Residen		ecify)
25. Was case referred to medi examiner? 1 ∐ Yes 2€ No	Hospital: 1 🕰		of 39a lawaret	20d Dosseiha hav		
25. Was case referred to mediexaminer? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pen 2 ☐ Accident inve	Hospital: 1 28a. Date o (Month stigation		of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	v injury occurred	
25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Penieve 2 Accident inve 3 Suicide 6 Cou	Hospital: 1 28a. Date o (Month stigation)	Injury 28b. Time	Work? M 1 Yes 2 No		et and Number or F	iural Route Number,
25. Was case referred to mediexaminer? 1 Yes	Hospital: 1 Date of (Month stigation ld not be mined) 28e. Place buildin ying Physicien: To the	Injury 28b. Time Injury of Injury - At home, farm, sg, etc. (Specify) Dest of my knowledge, dealers of examination and/or in	Work? M 1 Yes 2 No	28f. Location (Stre City or Town,	eet and Number or F State)	s stated.

State Registrar



Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Dav Year **Physician** 1605 M 01 06 ALICE COLGAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RAGIONAL Peninsula HICONICO SALISBIM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Days 1 M 2 R F Yrs Director 161-24-0954 3 - 10 - 373 PA. Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Exertiner must be notified at 1 Yes 2 No Director Worcester 28a-f MD. Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20 Hingham Lane itams 23a 21811 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Dono ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7/ h and Mental Hygiene." 7 Is marked othar then "n College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter J. Cooke ဥ Stromberg Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If itam 27 Is any injury or other trau once. Joseph T. Colgan 20 Hingham La. Ocean Pines, of Disposition (Name of Date 20c. Local Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley MG 1-11-05 Timonium, Md. 21. Signatore of Funeral Service License 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md. 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADETIC VALVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MITEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed SCHEMIC ARDIOMYOFATHU ng physician ar as the burial-to Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an has autopsy performed? 2 No 2 No Division of Vital 1 Yes 1 Yes Hospital or Attanding Physician: ral director 25. Was case reterred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours tha Funeral Dirace 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 1 46536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY Med WEHBERG 100 E. Carroll ST MD 31. Date filed (Month, Day, Year) State JAN 1 1 2005 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		partment of Fertificate of		ental Hygien	ZUUS	01759
			Decedent's Name (First, Middle, La	ist)				2. Date of Death	0.	3. Time of Death
	Physic		Denald Eve	gene Ci	ronise			January D.	ay Year	Δ.,
	/Medi		4a. Facility Name (If not institution, gir		10(1130	4b City Town o	r Location of Death		c. County of Death	
	Examir	ıer						1		
	Funenal		WASHINGTON COUNT 5. Social Security Number 6.		e (In yrs. last birthda		AGERSTOWN If Under 24 Hrs.	8. Date of Birth	WASHI	
	Funeral Director			1 ⊠ M 2□F	74 Yrs.	Months Days	Hours Min.	(Month, Day, Year		place (State or Foreign Intry) VT ANTO
			Usual Residence of Decedent		/4		<u> </u>	MARCH 7, 1	930 MAR	YLAND
	ylanc 10W		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar	to	MARYLAND WASHING	GTON		F	OONSBORO			1 X Yes 2 □ No
	the roll	Director	10e. Street and Number	<u> </u>		10f. Zip Code	0011020110	10a. C	itizen of What Cou	intry?
	3a o		11 McKELDIN DRIV	tr			21713		U.S.A	•
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show to Madical Evertine trivial be rolling a	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13			city Yes or No-	14. Race - Amer	
10	fter c	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🔯	No	If Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)	Black, White	
33	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify: WI	HITE
21215-0036	2 hou	Completed by	15. Decedent's E		16a. Dec	edent's Usual Occup	ation	16b. I	Kind of Business/Ir	
7	nin 7.	pie	(Specify only highest gr		(Gir	re kind of work done DO NOT use retired	during most of working)	ng		,
212	filed with Hygiene. ther than	Eo	12	College (1-4or 5	D+)	BRAKEMA	N	R	AILROAD	
	filed Hygie other ent, I	a	17. Father's Name (First, Middle, Last	')				(First, Middle, Maide		
an	Mental arked o	ToB	ROSS CRONISE				FRANCES '	V JONES		
Maryland	2 should and Men la marke aumatic	-	19a. Informant's Name/Relationship	Type, Print)	19b. Ma	ilina Address (Street		I Route Number, City	or Town State Zi	n Code)
Ĭ	and 2 ealth a n 27 la		NANCY J. CRONISE	/SPOUSE				NSBORO, MA		21713
ð,			20a. Method of Disposition	BLOCOL	20b. Place of Dis	position /Name of	D		ocation - City or T	
Baltimore,			1 ⊠ Burial 2 □ Cremation 3 □		1	ematory or other plac	1	. 6		
	pernit. Page Department o Important: If any injury or once.		' 4 □ Donation 5 □ Other (Speci 21. Sign ture of Full, a Spryi Lic-	nsee	The second secon	L CEMETER 22. Name and Addre				MARYLAND
Ba	permit. Page Deportment of Important: If any injury or once.					AST FUNER	AL HOME '	7606 Old Na		
	_		23a. Part 1. Enter the disease or com				1	Boonsboro,	Maryland	
п			shock, of heart failure. List only	one cause on each in	10.	mer the mode of dyli	ig, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset and Death
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	ped sit	ine	if any, leading to immediate cause. Enter U. derlying Cause (Disease or injury	1/1	a consequence of):				- 4	Trans.
	and -tran	Examiner	that initiated events resulting in death) Last	c	a consequence of):					- Cours
68760,	cate be executed physician and the burial-transit			000 10 (01 00	a consequence or,				i i	V
87	physicate physicate	dical		_ d						
	ding se as	/Me	IF FEMALE:	22a If you outcome	of programmy					
Вох	death certifi e attending I od for use as	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy		1	23d. Date of delive Month	ery Day Year
o.	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death 5	Other (specify)				,
۵.	The law requires that the te bas been signed by th bage 2 should be detache		Part II. Other significant conditions	contributing to death by	ut not regulting in the	undorwing onus and	on in Port I	23a Did tobassa	uaa aantributa ta t	he cause of death?
JS,	uires t signe Id be (by	, at the original and the contract of the cont	John Daning to Godin Di	at not resulting in the	underlying cause give	en in rout.			pably 4 🗀 Unknown
Record	w requ been should	ompleted						1 105 2	Mo 3 Prot	Dably 4 DOTKHOWN
ec	alaw nast	nple						24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
		Cor						performed? 1 ☐ Yes 2 ☐ No	death? 1 ☐ Yes	2 □ No
Vital	Phyaician: this certific ral director.	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of \	Physi this c	္	1 ☐ Yes 2 ☑ No	Hospital:		ent 3 DOA Oth	er: 4 Nursing Hom	ne 5 Residence	6 ☐Other (Specif	(y)
	ffer ffer ine	on:	27. Manyler of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. Time Injury	of 28c. Injun Worl	/ at 2 k?	8d. Describe how inju	ry occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident Investigatio			M 1 🗀	Yes 2 □ No			
Division	tal or Attendi s after death. al Director: A ed in by the fu	ertification;	3 Suicide 6 Could not be determined		ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office	2	 Location (Street ar City or Town, State 	nd Number or Rura e)	al Route Number,
	ital (O	/				1			
	e Hospital (124 hours at e Funeral D letely filled i	edical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Medicel Exer	nysicien: To the best on miner: On the basis of and manner sta	examination and/or i	th occurred at the tim nvestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause(s d at the time, date and) and manner as s d place, and due to	tated. the cause(s)
	To the Hos within 24 ho To the Function	Med	29b. Signature and title of certifier	And making sta		29c. License	e number	29d Da	te signed (Month,	Dev. Year)
1	F 3 F 8			Maria			62223	1 -	11-04	, , , o ,
•			20 Name and address of account	Vi) Victoria sauga of di			ULLLA	1	11	
1	N-15		30. Name and address of person	Red cause of d	eath (Item 23a) (Type	17 142	n nd	21740		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	mul ar's Signature	/ //	1. 1.0	- 17-0		
	Registr		JAN 122	005 Sucre	~ B. B.	nek				
DH	MH 17 Rev 1/2	001			14					

ORIGINAL

Dhari		Decedent's Name (First, Middle, I	Last)					2. Date Mon	of Death	ay Ye		Time of Death
Physic /Medi			carmona		sidy			Jan	uary 4	2005		11:50p
Exami	ner	4a. Facility Name (If not institution, g		r)		ity, Town, or L	ocation of D	eath		c. County of D		
uneral		Hillhaven Nursin 5. Social Security Number 6	6. Sex 7. A	ige (In yrs. last	birthday) If Un Month		If Under 24 Hours	Hrs. 8. Date	of Birth th, Day, Year	rince 9.	George Birthplace	(State or Fore
Director		577 28 8257 Usual Residence of Decedent	1□ M 200 F	85	Yrs.	IS Days	TIOUIS I			919 V		
how		10a. State 10b. County		10c. City, To	own or Location						10d. l	nside City Lin
ilane. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Director	Maryland Montgo	omery	Bethe								I∏Yes 2 ² ⊟
Sa or 2 Libera	i Dir	10e. Street and Number			10f.	Zip Code			10g. C	itizen of What	t Country?	
ems 2:	Funerai	5915 Kingswood F	12. Was Deceden Armed Forces		13. Was De	20814 cedent of Hisp pecify Cuban		? (Specify Yes uerto Rican, et	or No-	14. Race - A		ndian,
or Ite	by Fu	1 Never Married 2 Married 3 X Widowed 4 Divorced	d 1 Tes 2 2	No			Specify:	dello ricali, el	<i>(.)</i>	Specify:	White, etc. Whit	:e
atural Ical Ex	ted b	15. Decedent's	Year or Dates:		6a. Decedent's U	sual Occupation	ion		16b. I	Kind of Busine	ess/Industr	y
than "n the Med	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	life. DO NO	_	ring most of	working				•
other th		12 17. Father's Name (First, Middle, La	zet)		Home	maker	9 Mother's	Name (First, M	Aiddle Maide	Own]	Home	
0 0	o Be	William Langloi				,		ced Gu		in Jumame)		
Department of Health and Menta Important: If item 27 Is marked, any injury or other traumatic evence.		19a. Informant's Name/Relationship		1	9b. Mailing Addre	ess (Street and				or Town, Stat	e, Zip Cod	(e)
om 27 sher tr		Linda P. Barbern	nitz / Daug		1003 Ca		oad Si	llver S				20904
Q = = 0		20a. Method of Disposition DEBurial 2 ☐ Cremation 3		е сете	tery, crematory o	or other place)	1			Location - City		
ortant ortant injury		' 4 □ Donation 5 □ Other (Special Signature of Funeral Signature of Fun	1	Mt. C	Olivet C	emetery and Address	y 1	/8/2005 lines R	Was	hingto	n, D.	C
Impo any ir			4 /				' F	lines R	inaldi	Funera	al Ho	mo
		- Common !	* such	×	11800	New H:	amnehi	re Ave	Cilvo	r Cori	no MD	2000/
		23a. Part1. Enter the disease, or co	omplications that cause hy one cause on each	ed the death. D	111800	New Ha	ampshi	re Ave	Silve	r Spri	ng MD	20902 proximate
ysician		I shock, or beart failure. List on immediate Cause (Final disease or condition	omplications that cause only one cause on each	line.	111800	New Ha	ampshi	re Ave	Silve	r Spri	ng , MD App Inte Ons	20904 proximate prval Between set and Death
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State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#1 perMD FCHD, TM01/11c2005cate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FREDFrederick Day 9,2005 **Physician** Month CRIDER January 1:11 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months MEM 2□F Director 228-56-6971 June 20, 1943 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumetic event. The Medical Examiner must be notified at Frederick Frederick Maryland Directo 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 132 Penwick Circle 21702 U.S.A. Items 23e death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "neturel", or Itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Spacify: **white** 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) drywall Mechanic construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Crider, Sr. Leonia Dash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Importent: If item 27 is rr any injury or other treum 132 Penwick Circle, Frederick, Maryland 21702 Maryanne Crider - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 01/12/2005 Frederick Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Sign w re of Funeral Service Licensee mille naron 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has performed? res 2 No Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check only one) examiner 2 ER/Outpatient Cther: 2 1 🗌 Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 3□ DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Time of After Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 0 (fem 23a) (Type, Print) Man Year) 32. Registrar's Signature State 2005 Registrar

				of Maryland / Depa	artment of Health and Martificate of Death	-	ne
	Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Barbara Ann DENDIS			2. Date of Death Month January 1	Day Year 1, 2005 8:25 p. M
}	/Medi Exami		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Death
			Beverly Health Care		Hagerstown		Washington
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔯	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Nov. 13,	9. Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	antion	NOV. 13,	
	Maryla I sho	to	Maryland Washington	Hagers			10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	with the a or 28a	Direc	10e. Street and Number 17956 Oak Ridge Driv		10f. Zip Code 21740	10g. (Citizen of What Country?
	leath	erai				acify Vac or No.	14. Race - American Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or flams 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be invitibed at an 2008.	Completed by Funeral Director	1 Never Married 2 Married 1 Yes.	s 2/XNo	Was Decedent of Hispanic Origin? (Spin Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
21215-0036	thin 72 ho e. an "natur Medical	pieted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) 16a. Decec (Give iffe. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
21	filed withi Hygiene. other than	So	12 0		emarketer		fundraising
Maryland	I be fill H and I had out	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Maide	, and the second
IZ K	2 should be f and Mental I is marked of aumatic eve	10	Michael George Betsko 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	ATTITE V	Veronica B	
	and 2 seath an n 27 ls.		Sue Sleeper - sister		6 Oak Ridge Dr., I		
Je,	es 1 and 3 of Health fitam 27 r othar tr		20a. Method of Disposition	20b. Place of Dispo	Company of the Compan		Location - City or Town, State
Ë	Pages nent of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro `4 ☐ Donation 5 ☐ Other (Specify)	III State	en Cemetery 1/15	7/05 Ha	gerstown, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensing	uny 22	Name and Address of Facility MT 415 E.Wilson Blvd	NNICH FUN	
760,	Wedical Examine be executed // Medical end in a burial-transit end in a burial	icai Examiner	Sequentially list conditions, law, backg to i.i. ediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		ie Cardiovasci		Interval Between Onset and Death
.O. Box 68	death certifica e attending ph d for use as tl	Physician/Medic	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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ot		To	1 Les 5 P0140	☐ Inpatient 2 ☐ ER/Outpatient e of Injury 28b. Time of		ne 5 Residence	
Division	Attanding I r death. ector: After by the funer	Certification;	1 Natural 5 Pending (M 2 Accident investigation	onth, Day Year) Injury	Work? M 1 □ Yes 2 □ No		,
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	To tha Hospitat or vinithin 24 hours after To tha Funaral Direction completely filled in b	Medicai	(Check only 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or inv anner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause(sed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To To Con	2	29b. Signaturerand title of certifier Maysen 451	ap	29c. License number D 28365		ate signed (Month, Day, Year) $1 - 12 - 64$
£H	-2		30. Name and address of person who completed ca Manzav g. Slrcy	368 null &	Treet Hereges	terms I	1021740
U	Sta Registi		31. Date filed (Month Dev. Year) 2005	Registrar's Signature	who		

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Annie Pearl Delp 2:30 P M 2005 January 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport 8502 Neck Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 27, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M XXF Director 225-56-3726 Yrs 86 Canada Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "neturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be institlled at 1 Yes XX No Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8502 Neck Road 21795 Canada death by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "neturel", or Itel 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Charge Aide Mental Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James McFadven Norma Pearl McBurney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 end 2 st of Health ar of item 27 Ir Heather Gossard - Daughter 8502 Neck Road Williamsport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) * 4 ☐ Donation Smithsburg Crematory Jan. 12, 2005 Smithsburg, Maryland 21. Signal Te of F Ineral Service Los OSBOTAE ATTREFACTION HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** poolie disease or condition resulting in death) cerrin ar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijusy that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 [] No 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/11/05 232518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24-4 21 Wyand Drive Keedysville, Maryland 21756 Robert Guedenet M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien ? For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5, 2005 5:30 JANUARY HENRIETTA BREADY DEWITT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL SPA CREEK NURSING CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F 71 Yrs. MAR. 1933 MARYLAND 16, Director 215-32-6457 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🙀 № Directo DAVIDSONVILLE ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3913 BIRDSVILLE ROAD or Items 23a 21035 Completed by Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 XNo within 72 hours after 1 X Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No f Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) NEWS JOURNALIST 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 Is marked of JOHN DEWITT HENRIETTA BRADY of Health and Menta Item 27 is marked rother traumatic e 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANN L. WILSON/SECOND COUSIN 9212 ROSEANN PLACE, GAITHERSBURG, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State permit. Page Department of Important: If sny injury or once. CHESAPEAKE CREMATORY 01/07/2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HE HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy 1 Live birth Month Day Year ŏ in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. À 3 ☐ Probably 4 ☐ Unknown 2 No 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 Z No 26. Place of Death (Check only one) director Be 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ AND 2 ER/Outpatient 3 DOA ٩ within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending Injury 1 Avatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 To the Hospital of within 24 hours at 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier 30. Name and address of terain who completed cause of death (Item 23a) (Tyge, Print) 767 2108 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 1 2005

o Records, Division of Vital

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Margaret Ellen Duvall January 9, 2005 7:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2ĬF Director 217-07-1882 85 Oct. 8, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland_ Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or Itams 23a 26050 Woodfield Road - Apt. 13 20872 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after cal Hygiene. I Hygiene. I other than "natural", or Itan 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Montgomery County <u>School Bus Driver</u> Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental F Is marked of Byron H. Miller Eleanor M. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health itam 27 Norman E. Duvall, Jr. - Son 7984 Schooner Court, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of He
Important: If itar
any injury or oth 20c. Location - City or Town, State 1 Denation 2 □ Cremation 3 □ R
4 □ Denation 5 □ Other (Specify) 2 Cremation 3 Removal from State Jennings Chapel Cemetery 1/13/05 Woodbine, Maryland 21. Signalure of Fune al Seprece Licely e 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20272 Approximate Interval Between Onset and Death Immediate Cause (Final Mejoenedial Infacetton Physician wide resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial transit aureus 40 that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.O. I 9 Unknown ۾ been signed beshould be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Rinal faitene 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No page certificate 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 January 11, 2005 MO DO054636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed W. Haque, M.D. 700 Montclaire Avenue, Frederick, Maryland 21701 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 1 2005 Registrar

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			1 - State WCHD/SH 1	/14/05 pe	r FH	Cei	tificate of L	Death		Я	eg. No.	05	01/66
	Dhoraial		1. Decedent's Name (First, Middle,							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Alice Virginia	EVERITTS						January	11,200)5	11:30 p.M
	Examir		4a. Facility Name (If not institution,	give street and numb	oer)		4b. City, Town, or	Location o	f Death		4c. County		
			Clearview Nursi					ersto			Wash		
	Funeral		· · · · · · · · · · · · · · · · · · ·	5. Sex 7. 1 ☐ M 2 ☐ XF	Age (In yrs. las 86	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Nov. 30,	Year)	9. Birth	nplace (State or Foreign untry) yland
	Director		219-03-6628 Usual Residence of Decedent		00	113.				Nov.30,	1918	Mar	yıand
	/land		10a, State 10b. County	-	10c. City, 7	Town or Lo	cation						10d. Inside City Limits
	Many	ğ	Maryland Was	hington		Hage	erstown						1⊠Yes 2□No
	r 28g	Director	10e. Street and Number		·		10f. Zip Code			1	0g. Citizen of	What Co	untry?
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	dea	Funeral	11. Marital Status	12. Was Deced Armed Force	ent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Spe	cify Yes or No-		e - Ame	rican Indian,
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Maryland	2 should be tand Mental I is marked o	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a						
	s 1 and 2 should be filed within 72 hours after death with the Manylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at		Janis Peacher -	niece		836	Guilford	Ave.	, Ha	gerstow	n, Md.	2174	40
Baltimore,	of He of He of He roth		20a. Method of Disposition		com	e of Disponetery, cren	sition (Name of natory or other place	9)	D	ate	20c. Location -	City or 1	Town, State
Ĕ	Page nent ant: if		1 ⊠ Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		ale		en Cemete		1/15	5/05 H	lagerst	own,	Maryland
alti	permit. Pages 1 Department of H Important: If Its any injury or ot once.		21. Signature of Funeral Service Li	censee	-	22	. Name and Addres	s of Facility	/ M]	NNICH F	UNERAL	HOM	E
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau	ised the death. I	Do not ente	er the mode of dying	g, such as o	cardiac o	r respiratory arre	est,		Approximate Interval Between
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4	/Medical Examiner		resulting in death)	Due to (or	as a consequer	nce of):	11.1-						, .
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	ed Isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or injury		as a consequent							-8	chania -
•	and and	xan	that initiated events resulting in death) Last	C.	as a consequen	_				_		-	CANOTICO
8760,	death certificate be executed e attending physician and od for use as the burial-transit		()										
687	flicate p phy: as the	Physician/Medical		a.									
Вох	h certific anding p use as t	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Dat	e of deliv	very
	death e atter d for u	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnar	h 2 □ Fetal de it at time of deatl		Ectopic pregnancy Other (specify)				Mo	nth	Day Year
P.0	t the by th ache	hys	9 Unknown	9□ Unknow	n								
	es tha gned I	by F	Part II. Other significant condition	s contributing to dea	th but not resultin	ng in the un	iderlying cause give	n in Part I.		23e. Did tob	acco use conti	ribute to	the cause of death?
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မိ	G & C/	Pe e								24a. Was as	n 24b. V	Vere aut	opsy findings available ompletion of cause of
of Vital Records,	Th ate pag	Completed								perform 1 ☐ Yes 2	ned?	leath? □Yes	20 No
/ita	Physician: this certificanal director.	Be	25. Was case referred to medical examiner?	Hospital:			0.1		of Death	(Check only on	9)		
of 0	Physic this c	၉	1 Yes 2 No	1 □ Inp		/Outpatient		4 LAUR		ne 5 ☐ Reside			fy)
	ling After une	o	27. Manner of Death 1 Natural 5 Pending		Day Year)	b. Time of Injury	28c. Injury Work	at ? ′es 2.⊟N		8d. Describe ho	w injury occurr	ea	
<u>.s</u>	Attending ir death. ector: After by the fune	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be Gen Bloom of	Injury - At home	farm stre	eet, factory, office	63 2 11	_	8f Location (St	reet and Numb	ar or Rur	al Route Number.
Division	i or Attend after death Director:	Certification;	4 Homicide determin	building	, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	ot, ractory, office			City or Town		J. O. 718.	ar riodio ivanibor,
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying	Physicien: To the b	est of my knowle	dge, death	occurred at the time	e, date and	place, a	nd due to the ca	use(s) and ma	nner as s	stated.
	ne Ho 1 24 t ne Fu	edical	(Check only 2 Medical E) one)	caminer: On the basi	s of examination	and/or inv	estigation, in my op	inion, death	occurre	d at the time, da	ite and place, a	ind due t	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	116			29c. License				d. Date signed		
				NO VI	-		D00	622	223	3	Jan 1	22	005
			30. Name and address of person with	no completed cause	of death (Item 23	Ba) (Type, f	Print))	
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an	Registrar 1. Decedent's Name (First, Middle	e (ast)		Certificate of	Death	2. Date of Dea	eg. No.		3. Time of	Death
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cal ner	4a. Facility Name (If not institution	n, give street and nu	imber)	4b. City, Town, o	or Location of Death			unty of Death	0:33	
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	5. Social Security Number	6. Sex	7. Age (In yrs. last birth			8. Date of Birth (Month, Day		9. Birthp	place (State o	r Fore
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_	10a. State 10b. County		10c. City, Town					1	10d. Inside Ci 1 ☐ Yes	
Director		ARUNDEL	ANNAPOI							- (4)
D I	10e. Street and Number			10f. Zip Code		1		of What Cour	ntry?	
Funeral	1010 JIGGER COL		edent Ever in U.S.	21401			USA	Dana Amari	and to disc.	
E.	11. Marital Status 1 □ Never Married 2 🛣 Marri	Armed Fo	orces?	13. Was Decedent of I If Yes, specify Cub	pan, Mexican, Puert			Race - Americ Black, White,		
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	2□No ve Dates:	1 ☐ Yes 2 🔀 No	Specify:		Spe	ecity: WH	IITE	
ed	15. Deceden	t's Education	16a. I	l Decedent's Usual Occui			16b, Kind o	of Business/Inc	dustry	_
plet	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College ((Give kind of work done life. DO NOT use retire	during most of world)	king			,	
Completed	Elementary/Secondary (0-12)			LANT PATHOL	OGIST		BOTAN	Y		
Q)	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	ne (First, Middle, i	Maiden Sun	name)		
To B	WAKICHI ENDO				DAN KAT	0'.				
-	19a. Informant's Name/Relations	ship (Type, Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Number	City or To	wn, State, Zip	Code)	
	HELEN M. ENDO/V	VIFE	101	lO JIGGER C	OURT, ANN	APOLIS,	MD 2	1401		
	20a. Method of Disposition		20b. Place of cemetery	Disposition (Name of crematory or other pla	ice)	Date	20c. Locatio	on - City or To	own, State	
	1 X Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (S		FORT L'	, crematory or other pla INCOLN FRY	01./0	7/2005	RRFNT	JOOD, 1	AD)	
	21. Signature of Funeral Service	Vicensee /	Old III	22. Name and Addre	ess of Facility	360				
	Y LU NI	4		ADAMS FUNE ANNAPOLIS.			ARE,	814 BE	STGATE	RI
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequence of							
Examin	that initiated events resulting in death) Last	Due to	(or as a consequence of	f):						
dical Exami	that initiated events	Due to	(or as a consequence of	f):						
edicai	that initiated events	d 23c. If yes, ou 1 □ Live b	tcome of pregnancy birth 2 Fetal death nant at time of death	f): 3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у			Date of delive	-	'ear
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \$\sumeq 1 \text{Yes} 2 \sumeq No	d	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)		23e. Did tot			Day Y	
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To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions a vaminer? 1 Yes 2 No 27. Manner of Death	d	tcome of pregnancy pirth 2 Fetal death nant at time of death own leath but not resulting in	3 Ectopic pregnanc 5 Other (specify) the underlying cause gn patient 3 DOA Other me of 28c. Injury	ven in Part I. 26. Place of Dea her: 4 □ Nursing Hork	1 Ve 24a. Was a autops perforr 1 Yes 3	pacco use cos 2 No	Month contribute to the contr	Day Y ne cause of do pably 4 U psy findings a mpletion of ca	eath?
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are a conditions. 25b. Was case referred to medical examiner? 1 Yes 2 No 27b. Manner of Death	d	tcome of pregnancy pirth 2 Fetal death nant at time of death own leath but not resulting in	3 Ectopic pregnanc 5 Other (specify) the underlying cause gn patient 3 DOA Off me of 28c. Injuity M 1	ven in Part I. 26. Place of Dea	24a. Was a autops perform 1 Yes 3 th (Check only onome 5 Reside	pacco use cos 2 No 24 no 24 no 24 no 24 no 24 no 24 no 24 no 25 no 26 no	Month ontribute to the state of the state o	Day Y The cause of de pably 4 U psy findings a mpletion of ca 2 No	eath? nknow wailab tuse o
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar		Department of Health and Incertificate of Death	•	ne 2005 01760
Physic /Medi	cal	Decedent's Name (First, Middle, La	Friedman	ALC: Turnel and a	January	Day Year 3. Time of Death OG 2005 1427 M
Exami Funeral Director	ner	Montgomery General 5. Social Security Number 6. S 059-34-8000 1	al Hospital ex 7. Age (In yrs. last birth	4b. City, Town, or Location of Death Olney If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgor 10e. Street and Number 13003 Buckaneer 11. Marital Status	2d 12. Was Decedent Ever in U.S. Armed Forces?	or Location Spring 10f. Zip Code 20904 13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert	10g. (10d. Inside City Limits 1
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mantal Hygiene. 27 is marked other than "natural", or traumatic avant, the Medical Exami	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	1 ☐ Yes 2 ☐ No Specify: Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Specify: White Kind of Business/Industry
© 9 m ∪ %	To Be Co	17. Father's Name (First, Middle, Last) George Friedman 19a. Informant's Name/Relationship (ne (First, Middle, Maide	
Hea Hea		Ellen Neches/Sist 20a. Method of Disposition 1 Darial 2 Cremation 3 4 Donation 5 Other (Specification 2)	er In Law 3 Removal from State 20b. Place of I	Ellsworth Pl, Pitts Disposition (Name of crematory or other place)	sburgh, PA	15232 Location - City or Town, State
Baltimol permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licer		22. Name and Address of Facility Hin	nes-Rinaldi	
Physician / Medical Examiner physician and physician and the prutal-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		freumonts		Approximate Interval Between Onset and Death (e. manth)
O. Box 6: the death certific the attending p ched for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
cords, P. w requires that I been signed by should be deta		Part II. Other significant conditions or	ontributing to death but not resulting in t	he underlying cause given in Part I.		use contribute to the cause of death?
I Rec The law ate has b	e Completed	25. Was case referred to medical			24a. Was an autopsy performed? 1 Yes 2 XN	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No
ing Phy offer this	ToB	examiner?	Hospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tin	atient 3 DOA Other: 4 Nursing Ho	h <i>(Check only one)</i> me 5 ☐ Residence 28d. Describe how inju	6 □Other (Specify) ury occurred
E Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		City or Town, Stat	
To tha Hospital within 24 hours and To tha Funaral I completely filled	Medical	29a. Certifier (Check only one) 1 ★Certifying Phy 2 ★ Medical Examone 29b. Signature and title of certifier	sician: To the best of my knowledge, of iner: On the basis of examination and/of and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	ed at the time, date an	d place, and due to the cause(s)
1 To	-	Paul Banner 30. Name and address of person who described to the second	ompleted cause of death (Item 23a) (Ty	29c. License number M (10 (60335)		te signed (Month, Day, Year)
Sta Registr		Paul Bannen, 31. Date filed (Month, Day, Year) JAN 10 2	32. Engistrar's Signature	Philip Dr, Olney, MI	20832	

State of Maryland / Department of Health and Mental Hygierre 1 5

					Certificate of	Death		Reg. No.	, 0	01703
		1. Decedent's Name (First, Middle	, Last)				2. Dete of De Month		V	3. Time of Death
4	Physician	Edward B.	Gı	ant			Januar	ry 5, 20	Year 05	11:20 am
	/Medical Examiner	4e Fecility Neme (If not institution	, give street and number)			4b. City, Town, o	Location of Deat	th 4c. County	of Death	
	Examiner	Manor Care-Si	lver Spring			Silver	Spring	Mor	ntgom	ery
	Funeral	5. Social Security Number		e (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hr	s. 8. Date of Bi	rth		place (State or Foreign intry)
3	Director	216-44-2738	1⊠M 2□F	93	rs. Months Days	Hours Mir	OCt. 1	4, 1911		oraska
	pu A	Usuet Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1.	10d. Inside City Limits
	filed within 72 hours aftar death with the Maryland Hyglene. Ather than "natural", or items 23a or 23e-f show ant, the Medical Examiner must be notified at e Completed by Funeral Director		gomery		ver Spring					1 ☐ Yes 2 No
	in the Ma or 28e-f s be notified	10e. Street end Number			10f. Zip Code			10g. Citizen of \	What Coul	ntry?
	3a o	14400 Homecre	st Road, #1	52	209	06		Ţ	JSA	
	r items 23s	11. Marital Status	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of tf Yes, specify Cub	Hispanic Origin? (Specify Yes or No	o- 14. Rac		can tndian,
0	Fu Fig.	1 ☐ Never Married 2 ☑ Merr	ed 152 Yes 2 ☐ N	1 0			ito nicari, etc.)		ck, White,	
00	af', o	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	WWII	1 ☐ Yes \$4 ☐ No	Specify:		Specify	v: Whi	ce
2	led within 72 ho lygiene. her than "natura nt, the Medical I	15. Decedent (Specify only highes		16e.	Decedent's Usual Occu (Give kind of work done	pation	orkina	16b. Kind of B	usiness/In	idustry
21215-0020	e. en nole	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use retire	ed)	z.m.ig			
	or the contract of the contrac		5+	Cer	tified Public			Federal		ernment
b	d oth	17. Father's Name (First, Middle,	Lest)				ame (First, Middle	a, Maiden Surnan	10)	
<u>la</u>	Ment Ment Ment Parked Parked To I	Alex Grant				Mary	Goober			
Maryland	and and sum	19a. Informent's Name/Reletions	nip (Type, Print)		Mailing Address (Stree			-		
	and alth	Julia F. Grant	/ Wife	1	4400 Homecr	est Road	1, #152,	Silver	Sprir	ng, MD 20906
S	of He	20a. Method of Disposition	C Dominio I from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ice)	Date Jan. 6,	20c. Location -	City or To	own, State
altimore,	Pag Fire Ti	1 ☐ Burial 2 【ACremation 4 ☐ Donation 5 ☐ Other (Sp		Metropo	olitan Cremato	ry	2005	Alexand	dria,	Virginia
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.	21. Signature of Funeral Service	Bone O	7	22. Name and Addr Francis J 500 Unive	. Collina	s Funera vd, W, S	1 Home 1	inc	, MD 20901
		23a. Part1. Enter the disease, or	complications that caused	the death. Do n	ot enter the mode of dvi	ing, such as cardia	ac or respiratory a	arrest.		Approximate
4	Physician	shock, or heart failure. List	only one cause on each lir	10.	•	•				Interval Between Onset and Death
1	/Medical	Immediate Cause (Final							-	
	Examiner	disease or condition resulting in death)	a <u>Sepsis</u>	5 - 4 - 4						Days
13	E			Due to (or as a c	onsequence or):				1	
	ficate be executed physician and is the burial-transit	Convention lies and distance	b. —	Due to (or as a c	onsequence of:					
Ć,	certificata be executed ding physician and se as the burial-transit	Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Disease or injury	7.	Due to (or as a c	orisequence ory.				1	
68760,	a be a be a be cal	that initiated events	C	Due to (or as a c	onsequence of):					
89	g phy as th	resulting in deeth) Lest		5 4 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1	5.1004001.00 0.7.				1	
ŏ	nding use a	1	d							
m	death e atter ed for u	Part II. Other significant conditio	ns contributing to death bu	it not resulting in	the underlying cause of	ven in Part I	23b Did	tobacco use co	ntribute to	o the cause of death?
O.	at the death of by the attendetached for u		•					Yes 2X No		bably 4 ☐ Unknown
	as that igned I be det by P	Hypertension,	Dementia, Re	nai insu	irriclency			100 222110		
Division of Vital Records,							24a. Was	an autopsy		fere autopsy findings
ပ္ပ	w rec						репо	ormed?	co	vailable prior to empletion of cause death?
Ř	hysician: The law requir nis certificate has been s I diractor, paga 2 should To Be Completed						100	Yas 200No		□Yes 2□No
ā		25. Was case referred to medical			£	Of Dines of De				
5	certificactor iractor	examiner?	Hospital:	-t 0DED/Out	patient 3□ DOA Ot		eath <i>(Check only</i> Home 5 Resi		or (Casail	4.1
0		27. Menner of Death	28e. Date of tnjur	y 28b. T	ime of 28c. tnju			how injury occur		y)
o	ttending Phy death. :tor: After this / the funeral of Ication: T	1XXNatural 5 ☐ Pending 2 ☐ Accident investig	(Month, De)	<i>î Year)</i> Ir		ork?]Yes 2⊡No				
<u>s</u>	Attending Physician: r death. ector: After this certific by the funeral diractor, Iffication: To Be (3 ☐ Suicide 6 ☐ Could r	of be	ıry - At home, far	m, street, factory, office		28f. Location (Street and Numb	er or Run	al Route Number,
2	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	4 Homicide	building, etc				City or To	wn, State)		
_		29a. Certifier 1 Certifying	Physician: To the best of	f my knowledge.	death occurred at the ti	me, date end plac	e, and due to the	ceuse(s) and ma	inner as s	stated.
	thin 24 hours thin 24 hours the Funer impletely fil	(Check only 2 Medical I	xaminer: On the basis of end manner ste	examination end	Vor investigation, in my	opinion, death occ	urred at the time,	date and place,	and due to	o the cause(s)
	Vithir Fo th Somp	29b. Signature end title of certifier	1		29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
	, 1	I MA	1- 16all	41	_ D	5670	7- 1	JAN (0.	2005
	611	30. Name end eddress of person	who completed cause of de	eth (Item 23e) (Type, Print)	/ 1	•			
		Lalitha Tadike				enuo Ta	Larel MA	20707		
	State	31. Date fited (Month, Dey, Year)	32. P egistre	ar's Signature	altimore Av	citac, na	ATET IN	20101		
9	Registrar	JAN 0 7	2005 Breeze	e B.	Goarle					

			For State Registrar	State of M		d / Depa		t of H	ealth a	and M	_		05	01770
	0		1. Decedent's Name (First, Middle,	Last)							2. Date of Death		Voes	3. Time of Death
	Physici /Medio		RONALD DAV	is Guil	ES		,				JAN	qrh	2005	19:27 M
	Examin	er	4a. Facility Name (If not institution,			- 1 0			Location of			1	inty of Death	
			UNIVERSITY OF MA			ENTER last birthday)	If Under		If Under		9 Date of Righ		N/A	Jane (Chata - Farris
	Funeral Director		550 92 0085 Usual Residence of Decedent	WILL OUT	53	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, NOV 23,	1951	Cour	lace (State or Foreign nry) ifornia
	yland how		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Ba-f s	Funeral Director	MD Howar	d	Co.	lumbia								1 □Yes 2X No
	vith th	Dire	10e. Street and Number	_			10f. Zip				10		of What Cour	•
	s 23e	eral	10713 Cottonwoo	d Way 12. Was Decedent	- Cuaria II	6 42.1		044		-:-2 (C	and a Van and Na		ed Sta	
٠,	fter d	Fun	11. Marital Status 1 □ Never Married 2 ★ Married	Armed Forces	?	3.	f Yes, spec	ify Cubar	n, Mexican	n, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
9	ours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□ Yes 2	No.	Specify:			Spe	ocify: Wh	ite
5	72 hc	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a, Deced	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition uring mosi	t of worki	ng	6b. Kind o	f Business/Inc	dustry
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			e retired)				TT:- '		
d 2	filed Hygie other	CO	17. Father's Name (First, Middle, La	5+		Proi	essor		18. Mothe	er's Name	(First, Middle, N		ersity	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygrene. I marked other than "netural", or items 23e or 28e-f show umatic event, I'm Medical Exer. II art mail be rothlisd at	To Be	Richard Charles]	Doris	s May	Berry			
Ž	and 2 sh salth and n 27 is m ar traum		19a. Informant's Name/Relationship Magdalena Guile								N Route Number, Columbia			Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or items 23a or 28a-f show any nighty or other traumatic event, the Marical Exist in all relating the notified at ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		C	lace of Dispo emetery, crem • Loui:	natory or of	her place					on - City or To	
Balti	permit. Depertin Imports any inju		21. Signature of Funeral Service Lice	ensee	40104									ly FH Inc. MD 21043
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death								CICY,	Approximate Interval Between
, -	Pnysician :	13 1	Immediate Cause (Final disease or condition	SEPS										Onset and Death WEEK
•	/Medical Examiner		resulting in death)	Due to (or as		uence of):								1 WELK
	LAGIIIIICI	-	Sequentially list conditions, if any, leading to immediate	b. END S		LTVE	R D	ISE A	SE					1 YEAR
	nsit	nine	Cause (Disease or injury	LEDAT	·	-								20 YEARS
Ć.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as										72.0.0
8760,	cate be physicia the bur	icai	•	d										
9		Physician/Med	IF FEMALE:								_	1		
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pre						Date of delive Month	ry Day Year
o.	t the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9☐ Unknown	it time of de	eath 5	Other (spe	ecity)						,
Δ.	res that igned by be deta	by Ph	Part II. Other significent conditions	contributing to death t	out not resu	ıltıng in the ur	nderlying ca	iuse givei	n in Part I.		23e. Did toba	cco use co	ontribute to th	e cause of death?
rds	w requires been sig should be										1 ☐ Yes	2 □ No	3 Prob	ably 4 XUnknown
Records,	e law re has bee je 2 sho	Completed									24a. Was an	24	b. Were autop	sy findings available
		Com									autopsy perform 1 Yes 2	od? No	death?	npletion of cause of
Vita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Literate							Check on one			
of	Physi this o	To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatient		A Other	4 Nur		ne 5 Resider)
O	ding h. After funer	tion	1 XNatural 5 ☐ Pending	(Month, Da	ay Year)	Injury	M	Bc. Injury Work'	at ? es 2.⊟N		28d. Describe hov	njury occ	urrea	
Division of	i or Attending Physician: after death. Diractor: After this certific i in by the funeral director.	flca	3 Suicide 6 □ Could not	be 28e. Place of In	jury - At ho	me, farm, stre		_		_	28f. Location (Stre	et and Nu	mber or Rurai	Route Number,
á		Certification	4 Homicide	building, e	tc."(Specity)				1	City or Town,	State)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier 1 Certifying 1 Check only one)	Physicien: To the best eminer: On the basis of and manner st	of examinati	vledge, death ion and/or inv	occurred a restigation,	it the time	e, date and inion, deat	d place, a	and due to the cau ed at the time, da	se(s) and e and plac	manner as sta e, and due to	ated. the cause(s)
	To the He within 24 To the Fe complete	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date sign	ned (Month, L	Day, Year)
			1 Bri T	Tuly MD			AU	41764	135 T	1580	3]	ANUAR	y 9th	2005
	-		30. Name and address of person wh	Y 22 SOL		23a) (Type, I	· ·	BALT	IMO	RE	MARYLAN	D	2120	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Pagistr	rar's Sinnat									
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m			1- State of Maryland Registrar 1- State of Maryland Registrar 1- State of Maryland 1- Registrar 1- State of Maryland 1-	1√Depa 3a&27	artmen per i	t of H me G e of L	ealth and M 341 3-3-0 Death	lental Hyo 5 tas	giene Reg. No.	005	01771
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth		3. Time of Death
	/Medic		Wayne Larry Green, Sr.					January	y 16	, 2005°	6:32 P M
	Examir	er	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital		-		Location of Death ashington	n		County of Death Prince	George's
	Funeral Director		5. Social Security Number 226−78−1187 6. Sex 1 1 M 2 □ F 52	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day ctober	7 Year) 28,1	9. Birth Coul 952 Virg	place (State or Foreign htty) inia
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Loc	cation						I0d. Inside City Limits
	Many -1 sh	to	Virginia Prince William Dale	e City							1 ☐ Yes 2√0XNo
	r 28a	Director	10e. Street and Number	2 OLLY	10f. Zip	Code			10g. Citiz	zen of What Cour	ntry?
	th wit	aiD	5649 St. Charles Drive		22	193			Unit	ed State	· - G
	ems ems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		Vas Deced	ent of His	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No-		4. Race - Americ	an Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any figury or other traumatic event, it is Marical Examinat must be notified at once.	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		☐ Yes 2	-	Specify:	rticari, etc.)		Black, White, Specify: B1a	_
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usua	I Occupat	tion		16b. Kin	nd of Business/In	dustry
7	ithin hen.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT us	e retired)	uring most of worki				
2	lled w tygier her ti			Progra	m Mar						lence Corp.
and	d be fi	Be	17. Father's Name (First, Middle, Last) William Green				18. Mother's Name			Sumame)	
<u> </u>	shoule nd Me mark matie	70	19a. Informant's Name/Relationship (Type, Print)	19h Mailin	a Address	/Street as	Milared and Number or Rura	Browde		Town State 7:-	Codel
<u>≅</u>	nd 2 s lith ar 27 is r trau		LaVera Green - Wife				es Drive				
altimore,	f Healitem			ace of Dispos metery, crem				ate		ation - City or To	
Ë	Page lent o nt: If ry or		- A series e la cionitation o la romoval rism otato	ntico .			Janua:	ry 24,	Tria	ngle, V	ircinio
a	rmit. partir porta y Inju	ı	21. Signature of Fune al gervice Licensee				of Facility Mou	ntcast1e	- Fiii	neral Ho	me
m	8 9 E 8 8	9	- Strice	4	143 D	ale	Boulevaro	i Dale	City	y. Virgi	nia 22193
	Physician		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Atherosclero	Do not ente	r the mode	of dying,	such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conseque	ince of):							
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	ence of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate outce. Enter this third Cause (Disease or injury that initiated events								
ó	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a conseque	ince of):							
8760	ate be nysiciá he bu	dical	d								
9	artifica ing pl	Med	IF FEMALE:								
ROX	eath certifi attending r	ician/Me	23b. Was decedent pregnant in the past 12 months?	leath 3□£	Ectopic pre				23	3d. Date of delive Month	ry Day Year
o.	that the de ned by the detached	Physic	1 Yes 2 No 4 Pregnant at time of dea 9 Unknown	.tn 5 🔲	Other (spe	icify)				11101111	oay roa
<u> </u>	that ned by deta	y Ph	Part II. Other significant conditions contributing to death but not resulti	ing in the und	derlying ca	use given	in Part I.	23e. Did tob	acco us	e contribute to th	e cause of death?
Kecords,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ed by						1 □ Y6	s 2 🗆	No 3 ☐ Proba	ably 4 20 nknown
ပ္ပ	s bee	piet						24a. Was a	n	24b. Were autor	sy findings available
	The tay ate has page 2:	Completed						autops perforn 1 2 Yes 2	ned?	prior to con death?	npletion of cause of 2□ No
VItal V	ysiclan: This contificate	Bec	25. Was case referred to medical axaminer?			- 2	26. Place of Death	-/-		19188	2010
010	di is	2	Hospital:	P/Outpatient	3 🗆 DOA	Other	4 Nursing Hom	ne 5 Reside	nce 6	☐Other (Specity)
	ing Ph	on:		8b. Time of Injury		c. Injury a Work?		8d. Describe ho	w injury	occurred	
S	Attending ir death. ector: After by the fune	icat	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be 38 Reas of Injury. At hom		М		s 2 No				
UIVISION	after after Direction by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	e, rarm, stree	et, factory,	office	2	8t. Location (Str City or Town	eet and . , State)	Number or Rural	Route Number,
	spita lours neral		29a. Certifier 1 Certifying Physician: To the best of my knowle	edge death	occurred a	t the time	date and place a	nd due to the co	1100/0\ 0	nd manner on at	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or inve	estigation, i	n my opir	nion, death occurre	d at the time, da	ite and p	lace, and due to	the cause(s)
	To ti withi To ti	ž	29b. Signature and title of certifier		29c.	License r	number	29	d. Date	signed (Month, E	Day, Year)
			Theydre H. Kind nums	/			C.M.E.	Ja	anua	ry 17, 2	.005
			30. Name and address of person who completed cause of death (Item 2)	3a) (Type, P	rint)	1400 L	D-1.4	24	1	1 04001	
					IIII ST	reet	, Dartimo	ore, Mai	cy⊥aı	na 21201	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	parti	P						

			riedse i	State of Manuar					_	
			1_ State	State of Marylan		rtificate of			U U D	01772
			Registrar 1. Decedent's Name (First, Middle, Last)				Dealli	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	I Decedent's Name (First, Middle, East)	Timenous	HAST	NGS		Month	Qay Year	
	/Media		20ANNE	1 IVILITION 3 1	777577	4h Cibi Tourn	or Location of Deatl	Jan	4c. County of Dea	1 10
	Examir	er	4a. Facility Name (If not institution, give s DEERS HEAD	HOSPITAL	CENTER	5AL151		' 0	Wico	
			DEERS HEAD 5. Social Security Number 6. Sex				If Under 24 Hrs.	8. Date of Birtl		
	Funeral Director			M 2X1F 68	Yrs.	Months Days		June 26,	1936 Mar	thplece (State or Foreign ountry) Cyland
	<u> </u>		Usual Residence of Decedent	00		L		our zo,	2500 1101	7=0.10
	/land		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Man Fed	ţ	Maryland Somerse	t. Pr	incess	Anne				1 ☐ Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	3a o		31740 Peggy Neck R	oad.		21853			USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-		
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No		0 1110411, 010.)		
8	72 hours after death with the Maryland naturel; or Items 23a or 28s-f ehow Jest Examble must be notified at	d by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:		10 163 222110	орвену.		Specify:	White
21215-0036	s within 72 hours after death with the Marylan liene. Then "naturel", or Items 23a or 28a-1 show then Wadrel Examiner must be notilised at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occu kind of work done	pation during most of wor d)	rking	16b. Kind of Business	/Industry
21	within ene. then "	gr	Elementary/Secondary (0-12)	College (1-4or 5+)						
7	Hygier Hygier Sther ti		12		911	Operator	1	ma /Finat Adiddla	Emergency	Services
Ē	be da la	Be	17. Father's Name (First, Middle, Last)				_	ne (First, Middle,	Maiden Sumame)	
3	should be and Mental marked of umatic even	ဥ	Howard	Timmons	10h 14-15-		Ida		Tyndall r, City or Town, State, .	Zin Cordo)
Maryland	C1 00 = 08		19a. Informant's Name/Relationship (Typ		1					
	s 1 and if Health Item 27 other tr		Sue Wise (daught 20a. Method of Disposition	er) 206. F	27266 Place of Dispo	Mason L esition (Name of matory or other pla	ane, Pri	icess Ani	ne, Marylan 20c. Location - City or	id 21853 Town, State
Baltimore,	of to	1 1	1 ☐ Burial 2 ☑ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			j.			
Ë			* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service □Lense							y, Maryland
Bal	permit. Pag Department Important: I any injury o		17712011	2000					fessional A	
			222 Part 1 Enter the disease or compli						oury, Maryl	and 21804 Approximate
- 8.			23a. Part1. Enter the disease, or complications shock, or heart failure. List only or immediate Cause (Final	^				or roop natory an		Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	SEPTE		IA				3 days
100	Examiner			Due to (or as a consec		P+ To-	_			MAN71+5
u		e	Sequentially list conditions, b	Durk to lor as a consec	monco of).					7,10 7.174
	ted	nin	Sequentially list conditions, if any, leading to uninequate cause. Enter Underlying Cause (Disease or injury	DERPH	ERAI	1 VASE	ular	Diseas	e	V R5
	be executed sician and burial-transit	Examin	that initiated events c resulting in death) Last	Due to (or as a consec	quence of):					
760,	siciar siciar e buri	call		DIABE	TES	MEL	とり丁りる	2		yrs
89	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit									
Вох	nding use a	N.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		75			23d. Date of de	livery
	death e atte d for	icia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c]Ectopic pregnanc] Other (specify) _	;y 		Month	Day Year
P.0	t the by the ache	Physician/Medi	9 ☐ Unknown	9□ Unknown						
S, F	res that the de signed by the a be detached to	by P	Part II. Other significant conditions con					23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b	ed	END STAGE	F RENAL	צוע	CASE		1 🗆 Y	es 2 No 3 P	robably 4 Unknown
S	s bei	piet	COPD					24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
of Vital Record	The law cate has page 2:	Completed	ATILERAS	CLEROSIS (PARD	IDVAS	CH /AR	perfor	med? death?	2 No
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical					ath (Check only o	/ -	
>	d is	To B	examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	her: 4 Nursing H	lome 5 Resid	ence 6 Other (Spe	cify)
	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	ork?	28d. Describe h	ow injury occurred	
Ö	andir parth. br: Al	atic	2 Accident investigation			M 1]Yes 2□No			
Division	irect irect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, str	reet, factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			1						
	Hosp 4 hou Fune lely fi	icai	(Check only 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the our arred at the time, o	ause(s) and manner a: date and place, and due	s stated. e to the cause(s)
	thin 2 the mpfet	Medicai	one) 29b. Signature and title of certifier	and manner stated.		29c Licen	se number		29d. Date signed (Mon	h Day Year)
	P S S		255. Signature and title of certifier	D	MI) 7	3390	5	Jan 8	2005
			Vu guna p	, which is	100	2 2	, , .		0	nd 21802
			30. Name and address of person who co	ANY MD	ш23а) (Туре. СЛО	Printi PA BOT	12015	SALIS	BURY 1	nd 21802
	C+	ate	31. Date filed (Month, Day, Year)	32. Braistrar's Sign		1 0100)			<i>v</i> , , ,	
	Regist		JAN 1 1 20	105 Serve	N 4	barle				

			1 - For State Registrar	State	of Maryla	nd / Depa	artment of H	ealth a		ental Hygi	9	15	01773
	Physicia	an	Decedent's Name (First, Midd	fle, Last)					1	2. Date of Death Month	Day Y	'ear	3. Time of Death
	/Medic	al		SHANK		HAI	RSHMAN		J		11 200		6:17 PM ^M
	Examin	er	4a. Facility Name (If not institution		umber)		4b. City, Town, or				4c. County of	Death	
			11020 PIN OAK					AGERST			WAS	HING	TON
	Funeral Director		5. Social Security Number 215-20-8748 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day 1 NOV • 18	1924	9. Birthpl Coup M	lace (State or Foreign ARYLAND
	land ow		10a. State 10b. Count	у	10c. C	City, Town or Lo	ocation					10	0d. Inside City Limits
	Many -1 sh	ō	MARYLAND WA	SHINGTON			H	AGERST	OUN				1 ☐ Yes 2 ☐ No
	r 28e	iec	10e. Street and Number	DILLIVOLOIV			10f. Zip Code	IOLITOI	.01111	109	g. Citizen of Wh	at Coun	try?
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Examiner must be notified at	Funeral Director	11020 PIN OAK	TERRACE				21740)			U.S	.A.
	deat	ner	11. Marital Status	12. Was De Armed F	cedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origi	in? (Spec	ify Yes or No-	14. Race -		
ထ္	after or Ite	E.	1 ☐ Never Married 2 ☐ Ma	rried 1 Tes	2 X No		1 ☐ Yes 2 ፟ No	Specify:	Fuelto R	ican, etc.)		White, 6	HC.
ဗ္ဗ	ural',	d by	3 X Widowed 4 □ Divorce	d Year or	Dates:			орослу.			Specify:	WH	ITE
21215-0036	be filed within 72 hours after death with the Marylan Hydiena and Hydiena and other than "naturat", or Items 23a or 28e-f show event, tre Medical Examirer must be notified at	Completed	15. Decede (Specify only high	nt's Education est grade completed)	(Give	dent's Usual Occupa kind of work done of	lurina most c	of working	9 16	6b. Kind of Busi	ness/Ind	lustry
12	within ene. then "	d L	Elementary/Secondary (0-12)	College	(1-4or 5+)	iiie.	DO NOT use retired		כזיי		TCE C	DE AM	CDADI OD
2	filed Hygie other	ပိ	12 17. Father's Name (First, Middle	. Last)			BUSINES			(First, Middle, Ma		KEAM	PARLOR
⊆	2 should be filed within and Mental Hygiene. Is marked other than aumalic event, Ite M	To Be	HARRY CLINE SH							IAN STI			
, Mar	カチトン		19a. Informant's Name/Relation		CE		ng Address (Street a					ate, <i>Zip</i> 2171	,
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 ony injury or other 2005.		20a. Method of Disposition 1		State	cemetery, crer	esition (Name of matory or other place VN LUTH. (Da /14/	2005	Oc. Location - Ci		
Balti	permit. I Departm Importai eny injui		21. Signature of Funeral Service	Licensee	7606 0	LD NATIO	ONÁL						
			23a. Part 1. Enter the discase.	merman	caused the de-	ath. Do not ent	BAST FUN				ORO, MAI	RYLA.	ND 21713 Approximate
	Physician		shock, or beart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on	each line.		~~e	1	W ~	eest-	ι,		Interval Between Onset and Death
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68760,	icate be ex physician s the buria	ical	n	d									
.O. Box (The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown	1 Live	utcome of pregi birth 2 Fe gnant at time of nown	tal death 3	Ectopic pregnancy Other (specify)				23d. Date of Month		ry Day Year
Records, P	uires that the de signed by the a Id be detached f	þ	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.					e cause of death?
CO	w require been si should I	iete								24a. Was an	24h Wa	re auton	osy findings available
al Re		Completed								autopsy performe	d? prid	or to com	npletion of cause of
Division of Vital	Attending Physician: r death. ector: After this certification the funeral director.	Be	25. Was case referred to medic examiner?	Hospital:		7	othe Othe			Check only one)			
ō	Phys r this ral di	. To	1 Yes 2 No	1 1 1		ER/Outpatier	I SU DOA	4 Nurs		e 5 Resident	ce 6 Other)
<u>_</u>	ding P. h. After funer	tion	1 ☑Natural 5 ☐ Pend	ing (Mo	of Injury nth, Day Year)	Injury	Work	ເ?ົົ່ ∕es 2 ∐ No		d. Describe now	injury occurred		
S	deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could	I not be	e of Injury - At	home farm str	eet, factory, office			f. Location (Stre	et and Number	or Rural	Route Number
<u>≥</u>	itel or A rs after el Dire led in b	Certification:	4 Homicide deten	mined 200. Plac	ding, etc. (Spec	cify)	oot, labtory, office			City or Town,		or ribras	TIODIO IVAINDOI,
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely tilled in by the	Medical	29a. Certifier 1 Sertify (Check only 2 Medice	ing Physicien: To the I Examiner: On the and ma	ne best of my kr basis of etamir nner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my op	e, date and pinion, death	place, an occurred	d due to the cau d at the time, date	se(s) and mann and place, and	er as sta due to	ited. the cause(s)
	To I To I	Σ	29b. Signature and title of certifi	er			29c. License	number	2	290	l. Date signed (/	Month, D	ay, Year)
			Jules	h 1		1n	VID	265	3		nucy	12	Lows
SI	1-25		30 Name and address of person	who completed car	ise of dealer (Ite	om 23a) (Type,	Print)	adi.	1/	4 . 0.1	0.1	600	a house hat
	Sta Registr		31. Date filed (Month, Pay, Yea	3 2005 32.	Redistrar's Sign		beeks	en	عد (own	per 1º	7	A LOWN IT
	11091311				And after the same	V. 12							

Funeral Director 27 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Nedical Examinar must be mailful at Director Funeral 3altimore, Maryland 21215-0036 \$ Completed al Hygiene. 2 should be fi and Mental F Is marked of permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or othar traum once. Pnysician

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Barbarg

17. Father's Name (First, Middle, Last) ROBERT ROY HAWKINS 19a. Informant's Name/Relationship (Type, Print) CHARLES E. MILLER, III/SON RR4 BOX 626, SALEM, WV 26426 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part . Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions any, leading to line addi-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-transit Due to (or as a consequence of): 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Donad Completed 24a. Was an autopsy performed Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier

2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** JANUARY 5, 2005 10:50 PM BARBARA JANE HAWKINS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Months Days Hours 1 ☐ M 2 😿 F 72 Yrs. 579-40-7961 1932 **NEW JERSEY** MAR. 26, Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No NC PITT GREENVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 B CHERRY COURT LANE 62246 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** 11 GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) PAULINE JEANNIE BLUE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State STEVENSVILLE CEMETERY 01/07/2005 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgetown Rd. 9600 Natasha 32. Registar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State Registrar

		1 - For Registrer	State of Ma	ryland / I		rtment			and M		iene2 ()	05	01775
	Ш	Decedent's Name (First, Middle, Last	st)					_		2. Date of Deat	h		3. Time of Death
Physic /Medi		EDITH E. 1	HOLLAND							JANUARY	08 2	Year 2005	8:34 P M
Exami		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location o	of Death		4c. County	of Death	
		HARFORD MEMORIAL I	HOSPITAL					E DE		E		HAR	FORD
Funeral		5. Social Security Number 6. S	ex 7. Age ☐M 21又 F	(In yrs. last bit		If Under 1		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
Director		216–24–1726 1 Usual Residence of Decedent	LW ZM'	76	Yrs.					Mar. 29	, 1928		yland
and		10a. State 10b. County		10c. City, Tow	vn or Loc	ation						1	0d. Inside City Limits
d ehc	ō	Maryland Hari	ford				do (Grace					1 ☐ Yes 2X No
the 28a	Directo	10e. Street and Number	LOTA		- 11	10f. Zip (Grace	-	1	0g. Citizen of	What Coun	try?
3a or	Ö	515 S. Stokes St	treet				210	078			US		,.
ite; INICAL INICAL AT LETO-0000 8.1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Item 27 is marked other than "natural; or Itams 23a or 28a-1 ehow other traumatic event, the Medical Eventirer must be notified at	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - Americ	
or Its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			Yes, speci □Yes 2			i, Puerto i	rican, etc.)		ck, White,	
ours jours	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:	•		L 165 2	MINO	Specify:			Specify	^{y.} Bla	ick
natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a	. Decede	ent's Usual and of work	Occupa k done d	ition <i>luring mosl</i>)	t of workir	ng	16b. Kind of B	usiness/Ind	dustry
within has	m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D								
Hed y		12 17. Father's Name (First, Middle, Last)				Diet	etic	Ser		(First, Middle, M	US Go		ent
in yidiilo ZiZishould be filed withir nd Mental Hygiene marked other than imatic event, its Manatic event, i	Be	James Lee							ie Co		naiden Suman	ne)	
Mar ylar	2	19a. Informant's Name/Relationship (Type Print)	10	h Mailing	Addrace	(Street a			DIE Route Number,	City or Town	State 7in	Codel
Man d2 s th an th an trau		Jacqueline Holla											Code)
os 1 and 20 Health Item 27	1 3	20a. Method of Disposition	ala / daugn	20b. Place o	of Disposi	ition (Nam-	e of		Mt.	Rainier	MD 2 20c. Location -		wn. State
Pages tment of tant: If It		1 Burial 2 □ Cremation 3 □		1	-	atory or oth	-	1	4 /4 .				22-2-5
그 문문을		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenters 		St. Ja				S of Facilit	1/15	5/05	Havre	de Gr	ace, MD
Dermit Depar Import any In		I dian "	20H			Lis	a Sc	cott :	Funei	al Home	. P.A.		
		23a. Part1. Enter the disease, or com-	plications that caused t	he death. Do	not enter	552 r the mode	of dvino	VIS S	treet cardiac oi	Havre	de Gr	ace,	MD 21078 Approximate
Filmoloison		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	11441	044	An.	,						Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	CONSEQUENCE	of)	VCC.	•						
Examiner			Pon	0 F	71/	MAN	0						
	Jer	Sequentially list corrultions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	e to (or as a	conseque ce	of):	0.0	001-						
cuted nd ransi	Examin	that initiated events	c. Dial	seier		Mel	U.T	was				I	
be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence	of):		Wite	INTOS	scle	volte	A		
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A o entitle ding p	/Me	IF FEMALE:	- W									1	-
attend for us	hysician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death		Ectopic pre						te <i>o</i> f delive onth	ry Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	me or deam	201	Other (spe	спу)						
that the ded by	0	Part II. Other significant conditions c	ontributing to death but	not resulting i	in the und	derlying ca	use give	n in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?
The Colds, T.C. BOX of The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as I	d by						-			1 □ Ye	s 2 No	3 🗍 Prob	ably 4 □Unknown
w red beer shou	iete									24a. Was a	24b.	Ware autor	osy findings available
he la he has	ompieted									autops perform	/ /	prior to con death?	npletion of cause of
ilan: T	Ö	25. Was case referred to medical						26 Place	of Death	(Check only one		1 🗌 Yes	2 No
ysici is cer direct	O.B	examiner? 1 Yes 2 No	Hospital: 1 Inpatien	2 ER/O	utpatient	3 DO/	Othe	april 1		ne 5□Reside		er (Specifi	·)
g Ph G	n:	27. Many r of Death	28a. Date of Injury (Month, Day		Time of		c. Injury Work			8d. Describe ho			/
ath.	atio	Natural 5 Pending 2 Accident investigation		rear)	irijury	М		es 2 🗆 l	No				
r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, fa	arm, stree	et, factory,	office		2	8f. Location (Sti City or Town	eet and Numb	er or Rura	l Route Number,
Ital o	Cer		Januari, otto						1	0.0, 0 0	, olulo)		
Hosp 4 hou Funai ely fil	edical	(Check only 2 Medical Exan	ysicien: To the best of niner: On the basis of e	my knowledge examination ar	e, death a	occurred a	t the time	e, date and	d place, a	nd due to the ca	use(s) and ma	anner as st	ated.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2:	Med	Une)	and manner state	ed.			_						
7 ¥ 0 0		29b. Signature and title of certifier	7. 11	10		290.) ~	number	1	25	od. Date signer	I (Month, L	Jay, Tear)
7		20 No. 20 M	ee /	ath Observation			a	966			C 11	187	
2		30. Name and address of person who	Cause of dea	kiri (item 23a)	Type, P	nnt)	4	Hil	wi	do Gr	Rico	MI	221071
St	ate	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	011)	1	Will	16	7'	٠٠٠٠	1000	10
Regist		JAN 1 1 20	05 Marie	AR .	Good	dis							

Certificate of Death

Jones

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Hagerstown

Reg. No.

Year

2005

Washington

4c. County of Death

1938

U.S.A.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Tyes 2 □ No

Approximate Interval Between

Onset and Death

Virginia

14. Race - American Indian. Black, White, etc.

Specify: Black

Transportation

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 Probably

Year

Month

2 🗌 No

2. Date of Death

8. Date of Birth (Month, Day, Year)

Month

January

10. Name and sess of serson to completed cause of death (Item 23a) (Type, Print)

SNBOMA

Year)

31. Date filed (Month Day)

Russe11

1⊠M 2□F

7. Age (In yrs. last birthday)

Yrs.

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

James

5. Social Security Number

Physician

/Medical

Examiner

Funeral

Registrar DHMH 17 Rev 1/2001

State

SH 1+

11110 00

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:47 P M MARK JOSEPH JOHNSON JANUARY 7, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F 218-70-0834 51 Yrs. Director JULY 1, 1953 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show event, the Medical Examiner must be rigitlised at 1 ☐ Yes 2 No Director MD BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 SEMINARY AVE. 21093 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) O DISABLED other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental . Pages 1 and 2 should be trained of Health and Menta tent: if item 27 is marked lury or other traumatic en AL JOHNSON BETTY JEAN GAENG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY HULL/MOTHER 1771 HARBOR DRIVE, CHESTER, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. ^ 4 □ Donation 5 □ Other (Specify) STEVENSVILLE CEMETERY 01/10/2005 STEVENSVILLE, MD 21. Signature of Euneral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Recurrent pneumonia appration wrecks /Medical Due to (or as a consequence of): Examiner months Orophory ngeal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Cher (specify) o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy performed? 1 Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NG 3 PiCl 1 ☐ Yes 2 PNo Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SANVARY 8 28303

State

31. Date filed (Month, Day, Year)

ARRON

32. Registrar's Signature

MO

1 2005

J. CHARLIES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

6601 N. Charles St Borrmone MD

		•	For State	Stat	e of Ma	aryland	d / Depa	ırtment <i>tificate</i>			ind Me	ental Hy	giene Rag. No		_	01778
			Ragistrar 1. Decedent's Name (First, Middle	e, Last)								2. Date of De	nah			3. Time of Death
	hysici		Evelyn	к.			Jett					Month Januar	y 5	, 200	ear 5	12:05 a M
	/Medic xamin		4a. Facility Name (If not institution	n, give street an	d number)			4b. City,	Town, or	Location of	f Death			. County of I	Death	l
_	Admini		15101 Interla	chen Dr	ive,	Apt	. 101	4	Sil	ver S	prin	g		Mont	gom	ery
Fu	neral		5. Social Security Number	6. Sex		e (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs.	B. Date of Bio (Month, Da larch 1	th	9.	Birthp	lace (State or Foreign
	ector		577-20-3494	1 ☐ M 2 🔀	F	84	Yrs.	MOUTUS	Days	Hours	IV	larch 1	5, 1	.920		hington, DC
pu ,	>		Usual Residence of Decedent 10a, State 10b, County			10c City	, Town or Lo	cation							1	0d. Inside City Limits
anyla	Show	5					ver Sp									1 ☐ Yes 2 ☐ ¥No
he M	THE STATE OF THE S	Director	Maryland Mont	tgomery		511	ver st	10f. Zip	Codo				10a Cit	izen of Wha	t Cour	
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eath	18 23 18 23	Funeral	13101 IIICELIAC		Decedent					nanic Orio	nin? (Spec	ify Yes or No		14. Race - /	Americ	an Indian
ter d	iner	F.	1 ☐ Never Married 2 ☐ Marri	Arme	ed Forces? Yes 2 🕱			Yes, spec	ify Cubar	, Mexican,	Puerto R	ican, etc.)		Black, \	White,	etc.
Lrs al	0.0	ρ	3 X Widowed 4 ☐ Divorced	If Ye	s, Give r or Dates:			I ☐ Yes 2	2 ⊠ No	Specify:				Specify:	Whi	Lte
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Meni	atic	은	David Patric									M. W				
2 sh	E E E	1	19a. Informant's Name/Relations					-	-			Route Numb	-		te, Zip	Code)
and lealth	her t	- 3	Christine Fede: 20a. Method of Disposition	rroll/	Niece	20h Pi	352 F ace of Dispo	_		ı, Pas	sader. Da	ia, Md		ZZ ocation - Cit	y or To	sun State
i ges	- S		1 🛣 Burial 2 ☐ Cremation		from State	Ce	Vetera	natory or of	ther place		anua	ry 13	Che1	tenha		WII, State
Dallimor			' 4 ☐ Donation 5 ☐ Other (S 21. Signature of Fungral Service		-	A III		. Name an			200	5	Mary	land		
paritimore, Marylatin ZIZIS-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	any le		Ceru Chu	Jasch.	Mod	u _	Fr	ancis	J.	Collí	ns F	uneral W, Si	Hom 1ver	e Inc Spri	ng,	Md 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications only one cause	that caused on each lin	t to death	. Do not ent	er the mode	e of dying	, such as o	cardiac or	respiratory a	rrest,			Approximate Interval Between
Pinys	ician	2 1	Immediate Cause (Final disease or condition				ular A	ccide	nt							Onset and Death 3 Days
	dical		resulting in death)	a	ue to (or as											
Exan	niner		Sequentially list conditions.				rotic	Heart	Dis	ease						3 Years
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the death certificate	phys s the	edicai		d										_		
D X O	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		s, outcome									23d. Date of	f delive	rv.
eath u	atter d for u	ciar	in the past 12 months?		Live birth Pregnant at			Ectopic pro Other <i>(sp</i>						Month		Day Year
ָב [ָ] בַּ	y the ached	nysi	9 Unknown	9□	Unknown											
OrdS, P	been signed by the should be detached	by P	Part II. Other significant conditi	ons contributing	to death b	ut not resu	ılting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contribu	te to th	e cause of death?
COLUS W requires	on sig uld b	pa	Acute Myocardia	l Infai	ction	1						10	Yes 2	□No 3[X Prob	ably 4 Dunknown
law re	s bee	Completed										24a. Was		24b. Wer	e auto	psy findings available inpletion of cause of
The T	te ha	E										auto perfe 1 ☐ Yes	ormed?	deat	h?	2□ No
VIICION:	s certificate has t lirector, page 2 s	0	25. Was case referred to medica	t						26. Place	of Death	(Check only				
Or VIIA Physicien:	direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	1 🗆 Inpatie	ent 2 🗆 l	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 🗆 Nur	rsing Hom	e 🐬 Res	dence	6 Other (Specify	1)
n OI	: Atter this certifica s funeral director, p		27. Manner of Death 12√Natural 5 ☐ Pendir		Date of Inju (Month, Da	y Year)	28b. Time of Injury	- 1	8c. Injury Work	?		3d. Describe	how inju	ry occurred		
endii eath.	tor: A the fu	catio	2 Accident investi	gation				М		es 2□N						
DIVISION I or Attending after death.	urect n by l	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280.	Pface of Info	ury - At ho c. (Specify	me, farm, str	eet, factory	r, office		21	Bf. Location (City or To			r Rura	I Route Number,
pltel ours al	illed i		200 - 0. e/f	- Ob -i-i 3	F . 12 5 1	-6	1-4 - 41			1-1	1 -1 1	- d - d				
Hosp 24 ho	Fune tely f	edical		ng Physician: 1 Examinar: On		f examinat										
DIVISION To the Hospitel or Attending within 24 hours after death.	To the Funerel Direc completely filled in by	Med	29b. Signature and title of certifie					29c	. License	number			29d. Da	te signed (N	fonth,	Day, Year)
- 3 I	- ö		1 Am	0 1	mi	N	0		D24	543			J	anuar	у 6	, 2005
2	l		30. Name and address of person	who completed	cause of d	death (Item	23a) (Type.	Print)								
			James Rossi,	M.D.	3305	N. L	eisure	Worl	d D1	va.	Silve	er Sprin	g, M	20906	5	
• 8	Sta	ate	31. Date filed (Month, Day, Year,)	32 Registr	ar's Signa	enure /	will	-							
. F	Registi	rar	JAN 0 7	2009	Boun	2	to for									

			1 - For State Registrar	State of M	faryland / [Departm Certific			_	giene ()5	01779
	Physici		1. Decedent's Name (First, Middle, La Helen Louise KNC	,					2. Date of De Month	aath Day	Year	3. Time of Death 7:40 P. M.
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. (Location of Dea		4c. Count	y of Death	
	Funeral		Washington Count 5. Social Security Number 6.5		L ge (In yrs. last bin		nder 1 Year	erstown If Under 24 Hr		th	ingto	on place (State or Foreign
	Director		214-30-9103	1 □ M 2 💢 F	67	Yrs. Mon	ths Days	Hours Mir		y, Year) 9, 1937	Cou	otry) yland
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					1	10d. Inside City Limits
	e Mar	ctor	Maryland Washin	gton	Hag	erstow	n					1⊠Yes 2□No
	with the or 20	Dire	10e. Street and Number 119 N. Mont Vall	a Avenue		10f	Zip Code 21740	1		10g. Citizen of USA		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, It a Madical Examination and injury or other traumatic event, It a Madical Examination and injury or other traumatic event, It a Madical Examination and injury or other traumatic event, It and it is a madical examination and injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and it is a madical examination and its injury or other traumatic event, It and its injury or other traumatic event, It and its injury or other traumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give	? K No	If Yes,	ecedent of Hi		Specify Yes or No orto Rican, etc.)	- 14. Ra	ce - Americ lck, White,	
21215-0036	in 72 hour n "natural	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a.	Decedent's (Give kind o life. DO NO		luring most of w	orking	16b. Kind of E		
	ed with yglene er tha	Com	Elementary/Secondary (0-12)	College (1-40)		urse a	ssista	nt		nur	sing	home
Maryland	d be fill intal H; ed oth	Be	17. Father's Name (First, Middle, Last Simon Wesley Bro						ame <i>(First, Middle,</i> . Moore	, Maiden Suma.	me)	
ary	should and Me s mark umatic	P_	19a. Informant's Name/Relationship (19b.	Mailing Add	ress (Street a		Rural Route Number	er, City or Town	, State, Zip	Code)
	and 2 lealth a m 27 li		Earlene Miley -	daughter				arridge		ncock,	Mary1	and 21750
nore	ages 1 int of H t: if ite		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □		9	y, crematory	or other place	·	Date	20c. Location		
Baltimore,	permit. P Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		Cedar	22. Nam	e and Addres	s of Facility		I FUNERA	L HON	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death. Do r	415 not enter the	E. Wil	LSON Blv J, such as cardia	rd., Hage	rstown,	Md.	Approximate
	rnysician		Immediate Cause (Final disease or condition	a	tast	ic	0	an C	00		,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of	of):						tment
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequence o	of):					-	
	ecuted and -transi	Examin	Cause (Disease of injury that initiated events resulting in death) Last	C	s a consequence of	-4)						
58760,	icate be executed physician and s the burial-transit	dicalE		_ d	s a consequence of	л); 						
P.O. Box 68	The law requires that the death certifics ate has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectop 5 □ Other	c pregnancy (specify)				ate of delive	ory Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of	contributing to death	but not resulting in	the underlying	MOM	n in Part I.	29	obacco use con res 2 🗆 No	1 /	ne cause of death? ably 4 DUnknown
al Records,	ding Physician: The law r h. After this certificate has be funeral director, page 2 sh	Completed							24a. Was autop perfo 1 - Yes	rmęd?	Were autoprior to cordeath?	psy findings available appletion of cause of
Vital	rsiciar s certif directo	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpat	ient 2 ☐ ER/Out	trationt 3	DOA Othe	r	eath (Check only o			-
Division of	or Attending Physician: ifter death. Director: After this certifics in by the funeral director, in	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. T		28c. Injury Work	at		now injury occur		7
isio	death.ctor: A	Icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e con Dinas et la	njury - At home, far	M street for		′es 2□No	29f Location (6	Street and Alvel	and as Them	/ Daniel Abraham
<u>≥</u>	s efter s Dire ed in b	Certification:	4 Homicide determined	building, e	tc. (Specify)	m, street, rat	aory, onice		City or Tox	vn, State)	er or Hura.	l Route Number,
	To the Hospital or Attentwithin 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Property (Check only one)	nysician: To the bes niner: On the basis and manner s	or examination and	, death occur Vor investiga	red at the tim tion, in my op	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	To T To t	₹	29b. Signature and title of contifier.	16		h	29c. License	number DL6	473	29d. Date signe	d (Month, I)ay, Year)
15	H-3		30. Name and address of person who	completed cause of	death (Item 23a) (Type, Print)	100	, 1.	120 5	1007	0	Haa
Í	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		(11)		1,00	7147	<u> </u>	- CON
	Registr	ar	JAN 142	1000	un B.	Break	Z)					mI)

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

			For State		ryland / Depa				100 0	5 01781
	Dharisi		State Registrar AMFND FTFM Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physici /Medio	al			A. KRAMEI			January	8 ^{Day} 2005	
	Examin	er	4a. Facility Name (If not institution, give s Holy Cross Hospita	_		4b. City, Town, or Silver		ath	4c. County of	gomery
Ī	Funeral Director		5. Social Security Number 6. Sex 053-12-2912	7. Age	(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1920	9. Birthplace (State or Foreign Country) New York
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mary	ctor	Maryland Montgome	ry	Si	llver Spr	ing			1 ☐ Yes 2√ No
	with th	Director	10e. Street and Number 12812 Hammonton F	Pond		10f. Zip Code	0904		10g. Citizen of Wh	•
	death ms 23	Funeral		12. Was Decedent E	ver in U.S. 13. y	Vas Decedent of H	ispanic Origin? (Specify Yes or No-		- American Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Itams 23a or 28a-f ehow event, if a M.dical Examiner must be mailised at	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:	5	fYes, specify Cuba I□Yes 2█XNo	in, Mexican, Pue Specify:	erto Rican, etc.)	Specify:	white etc. white
15-0	"natur	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)	(Give	lent's Usual Occup kind of work done of OO NOT use retired	during most of w	orking	16b. Kind of Busi	iness/Industry
212	filed withir Hygiene. other then ent, If e M	omo	Elementary/Secondary (0-12)	College (1-4or 5-	-)	erinaria	•		Veterina	ry Medicine
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden Sumame,	
Maryland	should be in the Mental I marked o	٦ ا	Hyman Kramer 19a. Informant's Name/Relationship (Ty)		19h Mailin	a Address (Street		a Brodsky		toto Zia Codol
	alth an 27 is in traus		Lorraine Kramer, W	•				, Silver		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any Injury or other traumatic events.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		natory or other plac		Date		ity or Town, State
Itim	ntment		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyner (Service 100 Service	Mt. Lebar				Adelphi,	MD	
Ba	Departing Control of C	21. Signature of Furieral Services Conseed 22. Name and Address of Facility Torchinsky Hebrew Funeral 254 Carroll St., NW, Wash								C 20012
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or			Approximate interval Between				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death				
н	Examiner		ſ		consequence of):	Failuro				
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a	consequence of):	rainate				
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760,	icate be executed physician and s the burial-transit	edical E		I						
		Med	IF FEMALE:	0. 16						
P.O. Box	The law requires that the death certifi ste has been signed by the attending I cage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	•
	es that igned by be deta	by Ph	Part II. Other significant conditions con				en in Part I.			oute to the cause of death?
Records,	w require been si should b	eted	Chronic Obstructiv	e ruinona	Ty Disease	<u> </u>		1 🗆 Y	2121	Probably 4 Unknown
al Rec		Completed						24a. Was a autop perfor	sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 X Innatier	it 2 ☐ ER/Outpatien	t 3 DOA Othe	or.	eath (Check only or Home 5 - Resid		(Sanaika)
ion of	ting I. After Tune	atlon: T	27. Manner of Death 1 \(\) Natural 5 \(\) Pending 2 \(\) Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun Worl			ow injury occurred	
Division	tal or Attendis after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, stri (Specify)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory (illed in b	Medical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of ner: On the basis of and manner stat	my knowledge, death examination and/or inved.	occurred at the timestigation, in my of	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	ause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	Λ	()	29c. License	number	2	29d. Date signed ('Month, Day, Year)
)	D		alon K	lege	W ml		2261		January	8, 2005
	(0		30. Name and address of person who co Alan R. Segal, M.I				Spring	, MD 209	06	
	Sta Registi		31. Date filed (Month, Day, Year)		r's Signature					
	negisti	ar	JAN I U ZU	UJ Transcu	יקוין יטל ע	500084				

			1 - State of Marylai Registrar		artment of H			ene20)5	017	82
	Observation		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of I	Death
	Physici /Media		Clifford Odell Koontz, Jr.				January	⁷ 3, 200)5"	11:15	\mathbf{P}^{M}
•	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County			
			11112 Webb Wood Court 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Upper Ma:		O Data of Birth	Prince			-
	Funeral Director		246−38−3957 13M 2□F 73	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, July 8,	Year) 1931	Countr	ice (State or y) h Caro	•
			Usual Residence of Decedent				July 0,	+/31	NOICI	u care	/IIIa
	how		10a. State 10b. County 10c. C	ity, Town or Lo	ocation				100	d. Inside Cit	
	8a-f	cto	Maryland Prince Georges Up	per Man	rlboro					1 📉 Yes	2 No
	1 th	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Countr	y?	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	rai	11112 Webb Wood Court	1.0	20774			United			
_	item item	Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in the Armed Forces? 1 1 3 Yes 2 No 19		Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puert	Rican, etc.)		- American k, White, et		
93	hours after ural', or ite	by	W Con Chin	54	1 ☐ Yes 2 🕱 No	Specify:		Specify:	Blac	ck	
9500-61212	J within 72 hours after death with the Marylan ijene. I than "natural", or items 23a or 28a-f show I're Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa		ting 1	6b. Kind of Bus	siness/Indu	stry	
7	e filed within 72 h al Hygiene. I other than "natu vent, the Medica	nple	Elementary/Secondary (0·12) College (1·4or 5+)	life.	DO NOT use retired,)	wig.				
	led w lygier her th		4	Post	tal Clerk			U.S. I		l Serv	ice
and	t be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) Clifford Odell Koontz, Sr.				ne (First, Middle, M))		
Maryland	2 should be 1 and Mental H is marked of raumatic ever	2	19a. Informant's Name/Relationship (Type, Print)	19h Mailiu	ng Addrass (Street a		Alfredia		State Zin ('odel	
<u>8</u>	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or gither traumatic en once.		Melonay K. Glass/ Daughter		Utica Pla					,000	
ē,	Hear Hear		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of matory or other place	o)		Oc. Location - 0		n, State	
Ē	Page nt: #		1 Dullar 2 Dorellation 3 Directioval from State		Veterans	1/13	/05	Chelten	ham	MD	
Baitimore,	permit. Departminition of the permit of the		21. Signature of Funeral Service Licensee	22	2. Name and Addres						
<u>n</u>	89758		Undre Shompson		7400 Georg						0012
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ith. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Ir	oproximate nterval Betw	reen
9 1	Physician		Immediate Cause (Final disease or conditiona Failure t	o thriv	<i>r</i> e					Onset and D	aath
	/Medical Examiner		resulting in death) Due to (or as a conse								
		<u></u>	Sequentially list conditions, if any, leading to immediate		ner's Deme	entia			6	month	S
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
s	exec an an rial-tr		resulting in death) Last Due to (or as a conse	quence of):							
9/9	death certificate be executed e attending physician and id for use as the burial-transit	dical	d								
٥	artifica ing ph e as t	Med	IF FEMALE:			7.					
X R R	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregn 1 Live birth 2 Fet	al death 3	Ectopic pregnancy			23d. Date Mont	of delivery		ear
	y the a	Physician/Me	1 Yes 2 No 4 Pregnant at time of 9 Unknown 9 Unknown	death 5∟	Other (specify)					-/	
7			Part II. Other significant conditions contributing to death but not re	sulting in the w	nderlying cause give	n in Part I.	23e. Did tob	acco use contril	bute to the	cause of de	ath?
cords,	requires that een signed b hould be deta	d by	Diabetes				1 ☐ Yes	s 2 X □No 3	3 🗌 Probat	oly 4 □Ur	iknown
000	> 0 0	siete	Hypertension				24a. Was an		ere autops	y findings av	vailable
E E	0 - 0	Completed					autopsy perform 1 Yes 2	ed? de	rior to comp eath? ☐ Yes 2!	oletion of cal	use of
Vital	ysician: Th iis certificate director. pag	Be C	25. Was case referred to medical examiner?			26. Place of Dear	th (Check only one		1103 2		
0	S O D	2	1 ☐ Yes 2 💢 No Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3□ DOA Othe	II: 4 ☐ Nursing H	ome 5 X Resider	ce 6 Other	r (Specify)		
ŭ	iding Phi th. After thi funeral	on:	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	Work		28d. Describe how	v injury occurre	d		
<u>s</u>	ttend death stor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injuny. At the	nome form at		′es 2 □ No	206 i anation (Cta	and a med Marinets a		2	
DIVISION	spital or Attending Fours after death. Beral Director: After filled in by the funera	Certification:	4 Homicide determined 28e. Place of Injury - At building, etc. (Special	ify)	eet, factory, office		28f. Location (Str. City or Town,	State)	r or Hurai F	route Numb	ar,
	spita hours neral / fillec		29a. Certifier 1 Certifying Physician: To the best of my kn	owledge, death	occurrad at the tim	e, date and place,	and due to the car	use(s) and man	ner as state	ed.	
	To the Howithin 24 h To the Fur	ledical	(Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	ation and/or inv	vestigation, in my op	inion, death occur	red at the time, da	te and place, ar	nd due to th	ne cause(s)	
	To the Hospital of within 24 hours all To the Funeral D completely filled in	ž	29b. Signature and title of certifier		29c. License	number	29	d. Date signed	(Month, Da	ıy, Year)	
10	1+0			MI	D5250)3 (MD)		1/5/0	5		
1			30. Name and address of person who completed cause of death (Ite		,	T	MD 00	771			
	Sta	to			tile Lane	Largo	, MD 20	774			
100	Registr		31. Date filed (Month, Day, Year) JAN 0 7 2005 32. Pegistrar's Sign	IF A	MALL!						

		For State Registrar	State of	Marylan		rtment of I		d Mental Hy	giene 2 (05	01783
Physician		1. Decedent's Name (First, Middle, Last EVELYN R •		NIECKI				2. Date of Di Month January	eath Pay	Year	3. Time of Death 12:19 M
/Medica Examine		4a. Facility Name (If not institution, give	, man	per)	n to	4b. City, Town,	or Location of D		4c. Count	y of Death	
Funeral Director		5 Social Security Number 6 Se	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Age (In yrs.)	last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bi			lace (State or Foreign
		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation					0d. Inside City Limits
with the Marylan s or 28e-f show te redifical	tor	DE Sussex			Georget						1 ☐ Yes 2 ☑ No
vith the	Director	10e. Street and Number				10f. Zip Code	-		10g. Citizen of	What Cour	ntry?
er deeth wi	Funeral	20254 N. DuPont	12. Was Decede	ent Ever in U.	S. 13. W	19947		(Specify Yes or N	USA	ce - Americ	ean Indian
J36	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	[₫No		Yes, specify Cub ☐ Yes 2 No		(Specify Yes or No Jerto Rican, etc.)	Bla Specii	ck, White,	
72 ho 72 ho	leted	15. Decedent's Edu (Specify only highest grad			16a. Deced	ent's Usual Occup kind of work done ONOT use retire	ation during most of	working	16b. Kind of B	usiness/In	dustry
4 withir rather in them	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		Worker	a)		Poultr	y Pla	nt
S do the state of	Be	17. Father's Name (First, Middle, Last)	•	'				Name (First, Middle	, Maiden Sumai	77e)	
ANE EDEE	2	Norman Ziegen 19a. Informant's Name/Relationship (T)			19b. Mailing	Address (Street		Fegley Rural Route Numb	er City or Town	State Zin	Code)
A S S S S S S S S S S S S S S S S S S S		Jan Lubiniecki, J	r Son		2 Can	vasback		elbyville			
Pages nent of one if it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 1 ☐ Donation 5 ☐ Other (Specify)		ato Cé	emetery, crem	ition (Name of atory or other pla emetery	ce)	Date 3-2005	20c. Location	City or To	own, State DE 19947
Baltim Baltim permit. Pag Department Importent: any injury o		21. Signature of Fineral Service Licens	Star	4	60	Name and Addre 9 E. Mar	ss of Facility ket St.	Short Fur , Georget	eral Se cown, DE	rvice 1994	s 7
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ications that cau ne cause on eac	sed the death	n. Do not ente	r the mode of dyi	ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a consequ	ierice oi):	edera	h	y loxel	me		
8760, cate be executed physician and site burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):	()		1518			
Phy cate	edical	_	d	as		- Les	/ ve	48,9			
Division of Vital Records, P.O. Box 6 To the Hospitel or Attending Physicien: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√No 9 □ Unknown		n 2 ∏ Fetal It at time of de	death 3 1	Ectopic pregnanc Other (specify)	<i>'</i>			te of delive	ry Day Year
ds, P. Jires that the signed by disperse details the details designed by the designed by the details designed by the designed by the designed by the designed by the designed by the designed by the designed by the designed by the designed by the designed by the designed	^	Part II. Other significant conditions co	ntributing to deat	th but not resu	ulting in the und	derlying cause giv	en jn Part I.)			e cause of death?
Cord w requir	ered		me	400	are,	cere	4~	24a. Was	Yes 2 No		
Division of Vital Records, to Attending Physicien: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be contified to the funeral director.	e Completed	25. Was case referred to medical	9					auto perfo	psy prmed? 2 No	prior to cor death?	osy findings available inpletion of cause of
Of Vita Physicien: this certific al director,	o	eyaminer?	łospital: 1 1np	atient 2 🗆 f	ER/Outpatient	3□ DOA Cth		Death <i>Check on o</i> g Home 5 ☐ Resi		er (Specify)
OD O		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Injur Wor	y at k? Yes 2 □ No		how injury occur		
Visio	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho	me, farm, stre	et, factory, office	143 2 140	28f. Location (City or To	Street and Numb	er or Rura.	l Route Number,
Ditel or urs after or area Dismilled in				1							1
Division To the Hospitel or Attenwithin 24 hours after death To the Funerel Director: completely filled in by the	медісаі	29a. Certifier (Check only one)	sician: To the be ner: On the basi and manne	st of my know of examinati stated.	wiedge, death ion and/or inve	occurred at the tire estigation, in my o	ne, date and pla pinion, death or	ace, and due to the ccurred at the time,	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
To the within To the comp	Ž	29b. Signature and title of certifier	1	1		29c Licens	e number		29d. Date signe	d (Month, l	
18		30. Name and address of person who co				rint)	3796 TRY MD		111		
State	е	31. Date filed (Month: Day, Year) 1 2			ure		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Registra	r	UNIV 1 1 2	000	due.	D. 19	raile					

			1 - For State Registrar	State of Mary	•	artment of rtificate of		Mental Hy	giene 0	05	017	84
			Decedent's Name (First, Middle, La	ist)				2. Date of De	ath		3. Time of	Death
	Physici		Granville	Lee		Light		January	7 12, 2	Year 2005	9:55	\mathbf{A}^{M}
	/Medio Examin		4a. Facility Name (If not institution, given	re street and number)			or Location of De	ath	4c. Count	y of Death		
н			13619 Grandview 1	Drive		Hager	stown		Wash	ingto	n	
	Funeral		,		yrs. last birthday)	If Under 1 Yea			th Year)	9. Birthp	lace (State of	r Fo re ign
	Director		232-52-1210	1 X M 2 □ F	72 Yrs.	Months Days	s Hours Mi	n. (Month, Da April 2		West	Virgi	inia
	p .		Usual Residence of Decedent									
	show	L .	10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside Cit	
	Ba-ta	cto	MD Washing	gton	Hage	rstown					1 🗌 Yes	2 X No
	e or 2	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	try?	
	23a	Funeral Director	13619 Grandview D	rive		21742			U.S.			
	ie pus	Ine	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	(Specify Yes or No erto Rican, etc.))- 14. Ra	ce - Americ	an Indian, etc.	
36	or i	y Fi	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 No		1 ☐ Yes 2 🛣 No	Specify:		Specii	y:		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show than "natural" or items 23a or 28a-1 show a Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:						Wni		
5	n 72 "nat	lete	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occu kind of work don DO NOT use retir	e during most of w	orking	16b. Kind of 8	iusiness/ind	lustry	
12	withii iene. r than	Εď	Elementary/Secondary (0-12)	College (1-4or 5+)	Machi		0 0)		Manuf	actur	ina	
	filed v Hygie othar ant, II	ပိ	17. Father's Name (First, Middle, Last	·)	Haciii	LIICBC	18. Mother's N	ame (First, Middle			Ing	
aŭ	ad be ontal	Be c	Alexander Hamilto					Pearl Hes		,		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, tra Medical Examiner must be multiped at	2	19a. Informant's Name/Relationship (19h Maili	na Address (Stree		Rural Route Numb		State 7in	Code	
Z	d 2 sho th and t7 Is ma traum		Antionette Light/					e, Hagers			·	
ģ	1 and Health tam 27		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	Ob. Place of Dispo	sition (Name of	1	Date	20c. Location			
Baltimore,	Pages nent of int: If it iry or o		1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	cemetery, crei	matory or other pl	1			•		
표	it. Purtme		 4 □Donation 5 □Other (Special 21. Signature of Funeral Service Lice 		Rest Hav	en Cemet	ery 1/1	4/2005	Hagerst	own,	Maryla	nd
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		> SAA 105	7				st Haven				7/0
			23a Part1 Enter the disease or com	unlication that caused the				Avenue,		own,	Md. ZI Approximate	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	111.0	ΛΛ	\ \	as or roop, atory a	.,,		Interval Betw Onset and D	veen
	Physician /Medical		disease or condition resulting in death)	a. /////	LTPL	e (V)	yelio	ma			Om	enth
	Examiner			Due to (or as a co	nsequence df):		0					
н		-	Sequentially list conditions,	b. Due to (or as a co	nsequence of):							
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	,					;		
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8760,	cate be executed physician and the burial-transit	dical E	· ·	lia.								
687	icate phys			_ d							•	
	certi nding Ise a	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				23d Da	te of delive	n/	
Вох	atter atter	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnant Other (specify)	cy				-	'ear
P.O.	that the death certific ed by the attending p detached for use as	lys	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown								
	that ned b	d A	Part II. Other significent conditions	contributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use con	tribute to th	e cause of de	eath?
ds	w requires that s been signed b should be deta	d b						10	Yes 2 No	3 Prob	ably 4 ⊟U	nknown
S	w req beel shou	lete						24a. Was	an 24h	Were autor	esy findings a	valable
Re	03 03 CM	Completed by Physician/Me						autor	osy rmed2	death?	sy findings a apletion of ca	use of
ā	n: T ficate or, pa	e Co	25. Was case referred to medical					1 ☐ Yes		1 🗌 Yes	2 🗆 No	
₹	Physician: r this certific ral director,	m	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA	ther	eath (Check only o		10 11		
of	Phy	. To	27, Manner of Death	28a. Date of Injury (Month, Day Ye				Home 5K Resident	now injury occur			
on	ding th: Afte	tlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		ar) Injury		ork? ∃Yes 2⊟No					
Division of Vital Records,	Attending It death. actor: After by the fune	fica	3 Suicide 6 Could not b	28e. Place of Injury -	At home, farm, str	eet, factory, office)		Street and Numb	er or Rura	Route Numb	per,
Š	after Dire	Certification:	4 Homicide determined	building, etc. (S	pecify)			City or Tox	vn, State)			
	spits nours nera fille	alc	29a. Certifier Certifying Pl	nysician: To the best of m	y knowledge, deatl	h occurred at the t	time, date and place	ce, and due to the	cause(s) and ma	anner as st	ated.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page:	Medical	(Check only 2 Medical Example)	miner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my	opinion, death occ	curred at the time,	date and place,	and due to	the cause(s)	
	To the within To the Comp	Ž	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signe	d (Month, L	Day, Year)	
			Pludy	Lam	dr.	Cim	DL	6473	(01/1	210	5
			30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Print)	1	()			V.	
T	4-1		Hind Ham	dan. M	D: 11	30 (DALL	4 . Is	ladon	iata	on.	CIM
	Sta		31. Date liled (Month, Day, Year)	32. Registrar's	Signature	,			1		217	40
	Registr	ar	JAN 142	2005	N. A.	20.21			7			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Dete of Death Month Year 0 11:38 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Arden Courts Assisted Living Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Months Deys Hours Min. Dec. 30, 1911 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Months 1 XM 2 □ F 93 Yrs 234-26-9504 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Silver Spring Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 2505 Musgrove Road 20905 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Arms 2 No If Yes, Give Year or Dates: 1935-38 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: white Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) security aircraft industry 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lafayette Lambert Sarah Elizabeth Bennett 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Lambert - son 14816 Eastway Drive, Silver Spring, Md. 20905-5603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/15/05 Rest Haven Cemetery Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Femoral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or conditications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f 1 TYes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) 455 istat Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1,41 19 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Neturel 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

Examiner for usa as the burial-transit or Attending Physician: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical Be Completed Certification: To within 24 hours after death.

To the Funerel Director: After this completely filled in by the funerel di

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

Pages 1 end 2 should be filed within 72 hours aftar deeth with the Maryland

Baltimore, Maryland 21215-0020

tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental thirtyportant: If item 27 is merked of hand lings or other traumatic event

Physician

/Medical Examiner

> Š 25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death

> > 4 - Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrer's Signeture

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Atlanta Charles	Lancon Lancon Control		- 6 - 1 11 - (14	- 00-1 (T	D-1-

D-20974

ed cause of death (Item 23e) (Type, Print) 0

BRADLEY BLU

5H-12+1

State Registrar

edical

State of Maryland / Department of Health and Mental Hygier 0051 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** SADIE LICHTENSTEIN JANUARY 5, 2005 2:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2 K F Director 92 063-03-5713 6, 1912 NEW YORK AUG. Usual Residence of Decedent with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Mudical Examiner coust be notified at MARYLAND MONTGOMERY ROCKVILLE Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 6121 MONTROSE ROAD Items 23a 20852 UNITED STATES OF AMERICA Funeral filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 XNo Specify: WHITE Completed by Specify 3 XWidowed 4 Divorced naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER U. S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I snt: If Item 27 Is marked o SAMUEL PADNICK SARAH GOLDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ETHEL LEWIS - SISTER 20 SINCLAIR DRIVE, GREAT NECK, NY 11024 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 X Removal from State injury or MT. JUDAH CEMETERY 01/09/05 RIDGEWOOD, NEW YORK 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBRAL Immediate Cause (Final Physician THROMBOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause End Underly ground (Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE use 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death Day 5 Other (specify) P.O. detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has autopsy performed? 2 No of Vital 2/2No 1 Yes 1 Yes Hospital or Attending Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 00 Certification: To 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident investigation filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and tiple of certifier 29d, Date signed (Month, Day, Year) 2003 WD 10 ho completed cause of death (Item 23a) (Type, Print) 30. Name_and address of person MON TROSE D. 31. Date filed (Month, Day, Year) egistrar's Signature State 2005 Registrar

			For State Registrar	State	of Maryland	-	artment of H				iene	005	01787
			1. Decedent's Name (First, Middl	e, Last)					2	Date of Deat	h Day	Year	3. Time of Death
	Physicia /Medic		Yuk ()i		Lai				January	,	2005	2:45 P ^M
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	r Location	of Death		4c. C	ounty of Death	
			Randolph Hills				Wheaton				Mor	tgomer	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under Hours	Min.	. Date of Birth (Month, Day,	Year)	Cou	place (State or Foreign intry)
	Director		579-86-7975 Usual Residence of Decedent			88 Yrs.			A	ugust 2	24,19	916 Chi	na
	yland now		10a. State 10b. County	_	10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Mar.	ģ	Maryland Mont	gomery	R	ockvi	l1e						1 ☐ Yes 2X No
	or 28	Funeral Directo	10e. Street and Number				10f. Zip Code			1	0g. Citize	n of What Cou	intry?
	23a	a	11810 Timber La	ne			2	0852			U.	S.A.	
	tome	Jue	11. Marital Status	Armed i	ecedent Ever in U.S Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	14	I. Race - Ameri Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes. C	2 ⊠No Give		1 ☐ Yes 2 🖾 No	Specify:			5	pecify:	
3	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or freme 23e or 28e-f ehow event, the Mudical Exacili at mast be rodiffed at	ed b		Year or	Dates:	16a Dece	dent's Usual Occup	ation			16h Kind	As 1 of Business/Ir	ian
Ċ	in 72 " na sulle	Completed	(Specify only highe	st grade completed		(Give	kind of work done of DO NOT use retired	during mos d)	st of working		IOD. KIIIC	0 50301633/11	idustry
7	with iene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		ısewife				I	Domesti	C
ğ	othe othe	BeC	17. Father's Name (First, Middle,	Last)	'			18. Mothe	er's Name (/	First, Middle, M			
<u> </u>	uld by Venta rrked rice	To E	Unobtainal	ole				Chai	Yun	Wong			
Maryland 21215-0036	and h		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street a	and Numbe	er or Rural F	Route Number,	City or	Town, State, Zi	p Code)
Σ.	and and in 27		Mildred Chow /	Granddau			Stone P			-			
Baltimore,	permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If item 27 is marked other any injury or other traumatic event, once.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	m State 20b. PI	ace of Dispo metery, crei	sition (Name of matory or other plac	(e)	Dat	е :	20c. Loca	ation - City or T	own, State
Ĕ	Pag ment ury c		4 □ Donation 5 □ Other (S		I		leaven	0	1/06/	2005	ilve	er Spri	ng, MD
ğail	ermit epart nport ny in nce.		21. Signature of Funeral Service	Licensee									1 Home, Inc.
	707 4 0		Jan T.	Thee								Sprin	g, MD 20904
П			23a. Parti. Inter the disease, or sheek, or heart failure. List	only one cause on	t caused the death each line.	. Do not ent	ter the mode of dyin	ig, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Con	gestive	Heart	failure						Onsot and Death
			resulting in dealth)		o (or as a consequ								
		-	Sequentially list conditions, if any, leading to immediate Coronary Arter Due to (or as a consequence				Disease						
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	0 (01 23 2 00113040	ones ory.							
	and al-tra	xar	that initiated events resulting in death) Last	c. Due to	o (or as a consequ	ence of):				· · · · · · · · · · · · · · · · · · ·			
8760	certificate be executed nding physicien and use as the burial-transit	dical E											
89	ificate g phy as the	edic											
ŏ	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregnar		75				23	d. Date of deliv	ery
n	death ie atter sd for u	Icla	in the past 12 months? 1 ☐ Yes 2 🛣 No	4 □ Pre	e birth 2 □ Fetal gnant at time of de		⊒Ectopic pregnancy] Other (<i>specify</i>)					Month	Day Year
J.	at the de by the a stached	hys	9 Unknown	9□ Unk									
	es this	by F	Part II. Other significant condition			lting in the u	nderlying cause give	en in Part I		23e. Did tob	acco use	e contribute to t	the cause of death?
Z	w requir been si should I	ted	Diabetes Mellit	us, Type	II					1 🗌 Ye	s 2 🗆	No 3 ☐ Pro	bably 4 ⊠Unknown
Records,	law r as be 2 sh	Completed								24a. Was ar autops		24b. Were auto	opsy findings available ompletion of cause of
		Com								perform		death? 1 ☐ Yes	
Vital	slcian: Th certificate rector, pag	Be (25. Was case referred to medica examiner?						e of Death (Check only on	9)		
o to	Physical this contained and direction	2	1 ☐ Yes 2 🛣 No				nt 3 DOA Othe	4 (2) 190	rsing Home	5 Reside	nce 6	Other (Special	fy)
ב	ding P h. After t funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time o Injury	Worl	k?		d. Describe ho	w injury	occurred	
Division	Attendideath. ctor: A	Certification:	2 Accident investi 3 Suicide 6 Could					Yes 2□					
\leq	or Attendate death after death Director:	E	4 Homicide determ	ined 28e. Plac	ce of Injury - At hor Iding, etc. (Specify	me, farm, sti)	reet, factory, office		281	City or Town		Number or Run	al Route Number,
	spitel ours a lerel I		29a. Certifier 1X Certifvir	an Physicians To t	ha haat of my know	uladae deet	h annum of -1.1h - 1		d siese	el el			
	Hos Fur Tely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examination	ion and/or in	h occurred at the tim vestigation, in my of	pinion, dea	th occurred	at the time, da	use(s) ai ite and p	nd manner as s lace, and due t	o the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifie)	29c. License	e number		29	d. Date	signed (Month,	Day, Year)
	/ s + ō		· /// -	1 1	. [/		D EO	261				/	2005
	6		30. Name and address of person	who completed ca	us o death (Item	23a) (Type	D 522		egar,		anua	ry 4, 2	2005
			1500 Forest Gle		/ I	6.7			•				
	Sta	te	31. Date filed (Month, Day, Year)	32.	egistrar's Signat	ure							
	Registr	ar	JAN 0 7	′ 2005 £	egistrar's Signat	7 P							

			Fo.	State of Marylar				-		_	0.1300		
			For State Registrar			ertificate of			Reg. No.	.005	01/88		
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death		
	/Medic		Gennaro M. Lancelotta						8.		1:30 A M		
100 m	Examin	er	4e. Fecility Name (If not institution, give s Howard County Gener				or Location of De mbia	ath		ounty of Deal	tn		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthda	y) If Under t Yea	r If Under 24 H		1	Oward 9. Birt	thplace (State or Foreign		
	Director		216-03-0682	^{M 2□ F} 93	Yrs	Months Day	s Hours M	n. (Month, Day 3/1/191			de Island		
	land ow II		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or	Location					10d. Inside City Limits		
	Mary	tor	MD Howard		E11	icott Cit	7.7				1 □Yes 2 No		
	or 284	Funeral Director	10e. Street and Number		+	10f. Zip Code	<i>Y</i>		10g. Citize	en of What Co	puntry?		
	e 23e	rai	8617 Watkins Run C			21043				State			
10	ter de ritem inern	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 RYes 2 □ No 1 Q	42-	Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14	Black, White	e, etc.		
036	ours a	by	3 Widowed 4 Divorced	1 StYes 2 □ No 19 If Yes, Give Year or Dates: 194	5	1 ☐ Yes 2 ☑ No	o Specify:		S	ipecity: Whi	ite		
5	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. De	cedent's Usual Occive kind of work don b. DO NOT use retir	upation e during most of w	vorking	16b. Kind	of Business/	Industry		
7	within ene. then	Jupi	Elementary/Secondary (0-12)	College (1-4or 5+)			'ed')		D 1 -				
d	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or iteme 23e or 28e-f ehow event, the Medical Exeminer must be notified at	Be Co	17. Father's Name (First, Middle, Last)		Own	CT.	18. Mother's N	ame (First, Middle,		urant umame)			
<u>lar</u>	should be nd Menta i marked umatic ev	To B	Joachim Lancelott	a			Elvir	a Lombard	Lombardi				
Maryland 21215-0036	2 sho and is my raum		19a. Informant's Name/Relationship (Type Grace Lancelotta/		1			Rural Route Number					
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturel; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition			7 Watkins sposition (Name of rematory or other pl		rt Ellico		city, Mation - City or			
Baltimore,	Peges nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	BINOVALITORII SLALE		rematory or other pl rematory		2/2005		sville			
aĦ	Depermit. Depertm Importal eny injui		21. Signature of Funeral Service License				ress of Facility H	arry H. W	itzke	's Fam	ily F.H., Inc		
<u> </u>	8988		Then Collin	o Wille		4112 Old (Columbia	Pk. Ellic	cott	City,	MD 21043		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			ring, such as card	iac or respiratory arr	est,		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	emorrhage					3 days				
	Examiner		On a second to the same of the second to the	Due to (or as a consec Hypertension							years		
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	xecute and al-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	uence of):								
760,	ate be executed hysicien and he burial-transit	caiE	d							1			
89	ntificat ng phy as th		IF FEMALE:										
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	death	3 ⊒Ectopic pregnan	су		23	d. Date of deli	ivery Day Year		
P.O.	that the death certifical ed by the attending phi detached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	leath	5 ☐ Other (specify)					July 104.		
	The law requires that the death certifica lie hes been signed by the attending ph page 2 should be detached for use as th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							cco use contribute to the cause of death?			
Ş	w requires to been signer should be	ed b	Chronic Obstructive Pulmonary Disease							No 3 Probably 4 □Unknown			
Vital Records,	hes be	Completed	Hypothyroidism 24a						s an 24b. Were autopsy findings available opsy prior to completion of cause of				
a		Certification; To Be Corr						perform 1 Tes	med? 2 No	death? 1 ☐ Yes	2 □ No		
	d is		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Impatient 2	ER/Outpat	ient 3□ DOA	ther	eath (Check only on Home 5 Reside		Other (Case	- ihd		
o c			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inj		28d. Describe ho			any)		
Sio	Attending in death. ector: After by the funer		2 Accident investigation M 1 Yes 2 No										
Division of	l or Attending after death. Director: After in by the funer	ertifi							 Location (Street and Number or Rural Route Number, City or Town, State) 				
_	Hospitei 24 hours a Funerai [letely filled		29a. Certifier	Ician: To the best of my known	owledge, de	eath occurred at the	time, date and pla	ce, and due to the c	ause(s) ar	nd manner as	stated.		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	ation and/or	investigation, in my	opinion, death oc	curred at the time, d	ate and pl	lace, and due	to the cause(s)		
\	To the within 2 To the complet	Σ	29b. Signature and title of certifier	^		29c. Licer	ise number	2	9d. Date s	signed (Month	n, Day, Year)		
			30 Homosey	molecular and described	m 22-1 CT	D3829	96	Ja	nuar	y 8, 2	005		
100			30. Name and address of person who con Joseph F. Gibbons			napolis RI	Ellico	ott City,	MD	21042			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								
	Registr	ar	JAN 1 1 20	11) KRAMINE	H.	Angelis							

			For State Registrar	State o	f Maryland /		artment o			and N		giene ()	05	01	789
		Æ	Decedent's Name (First, Middle	le, Last)	-						2. Date of De		Year	3. Time	of Death
#	Physici /Medi		Sahr S.	Mor	lai						Januar	-	005	7:5	2 P M
	Examir	ner	4a. Facility Name (If not institution	. 3			4b. City, To		Location o	of Death		4c. Cour	ity of Death	1	
	Formul		Montgomery Ger 5. Social Security Number	neral Hosp	7. Age (In yrs. last bi	irthdav)	Olr	ney Year	If Under:	24 Hrs.	8 Date of Birt		ntgom		e or Foreign
	Funeral Director		217-25-9283	1 ⊠ M 2□ F		Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da May 28	, Year) , 1972	COL	rra Le	
	P .		Usual Residence of Decedent		140.00										
	laryla shov	5	10a. State 10b. County		10c. City, Tov									10d. Inside	City Limits es 2 🛭 No
	28a-1	Director	Maryland Mont 10e. Street and Number	gomery	SIIV	er	Spring	ode				10g. Citizen o	f What Cou		
	3a or		3901 Pepper	Tree Lan	e			090	6			Tog. Oilizen o	USA	iritiy:	
	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or iteme 23e or 28e-1 show event, the Madical Examinar must be multiled at	Funerai	11. Marital Status	12. Was Deci	edent Ever in U.S.	13. V	Vas Deceden	nt of Hi	spanic Orig	gin? (Sp	ecify Yes or No		ace - Amer	ican Indian,	
9	or Ite	/Fu	1 Never Married 2 Mar	If Yes Gi	2 No		fYes, specify I∐Yes 21⊑		Specify:	, Puerto	nican, etc.)	Spec	lack, White	, etc.	
003	hours ural',	d by	3 Widowed 4 Divorced	Year or D	ates:							I	Black		
21215-0036	in 72	Completed	(Specify only highe	nt's Education st grade completed)		(Give	lent's Usual (kind of work (DO NOT use :	done d	urina most	of work	ing	16b. Kind of	Business/Ir	ndustry	
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b	2 should be filed withir and Mental Hyglene. Is marked other than aumatic event, Ire M.	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Nam	e (First, Middle,			юр	
ylai	should be fand Mental He marked of umatic even	70	Aiah Stephen								a Mondel				
Maryland	s 1 and 2 should f Health and Men Item 27 le marke other traumatic		19a. Informant's Name/Relations Aiah Stephen								al Route Numbe				
	1 and Healtl em 27 ther t		20a. Method of Disposition	morrar/ra			sition (Name		Bend		crace, (ermant 20c. Location			0874
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 It any Injury or other tra once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State cemete	ery, cren	natory or other ven Cem	er place		anua	ry 25				
alt:	mit. Pages pertment of nortant: If I Injury or		21. Signature of Funeral Service	Licensee					- 1	2005 y.		Silver	Spri	ng, Ma	ryland
ñ	Depermination of the second of		Illier E	Bour	h	500	Unive	ers:	ity B	ins lvd,	Funeral W, Sil	. Home .ver Sp	Inc ring,	MD 2	0901
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that of	aused the death. Do									Approxim Interval B	ate etween
	Paysician		Immediate Cause (Final disease or condition			1	leart		fai	141	حما			Onset and	
8	/Medical Examiner		resulting in death)	Due to	o s a consequence	of):			101						
В	Lxammer	_	Sequentially list conditions,	b. Due to	1 y per t		No is							13 9	1ears
	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Z Due to	(or all argonisacioence	onjr							-1		
Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to	(or as a consequence	of):									
8760,	cate be executed only sician and the burial-transit	dical		d											
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о. В	at the dee by the ai	/sici	1 Yes 2 No	4□Pregr 9□Unkn	ant at time of death	5	Other (speci	ify)				N	fonth	Day	Year
Δ.	that the ed by detact		Part II. Other significant condition	ons contributing to di	eath but not resulting	in the ur	nderlying caus	se aive	n in Part I.		23e. Did to	bacco use co	ntribute to t	the cause o	f death?
Vital Records,	uires tha signed Id be de	d by	Chronic	Renal	failn			Ů			1 🗀 Y	es 2 No	3 🔲 Proi	bably 4	∃Unknown
00	w require s been si should I	jete									24a. Was	an 24b	. Were auto	opsy finding	s available
Re	The lav	Completed										sy med?	prior to co death? 1 \(\text{Yes} \)	ompletion of	cause of
ital		Be C	25. Was case referred to medica	ıl					26. Place	of Death	1 Yes	2 No	1 1 1 1 4 5	2 LI NO	
of V	Physiclan: this certific ral director,	일	examiner? 1 ☐ Yes 2 No	Hospital: 1 □ I	npatient 2 EPVO	utpatien	t 3 DOA	Othe	r. 4 🗆 Nui	rsing Ho	me 5 Resid	ence 6 🗆 O	ther (Speci	fy)	
	fter	no ::	27. Manner of Death 1 Natural 5 ☐ Pendir	'9		Time of Injury		. Injury Work	at ?		28d. Describe h				
Division	uttendi death. ctor: A y the fu	cat	2 Accident Investi 3 Suicide 6 Could	not be	of Injury - At home, fa	arm stee	M I		es 2 🗆 N		28f. Location (S	tennet and blum	abas as Dua	n I Davida Ali	
DΪ<	after Direction by	Certification;	4 Homicide determ	nined 200. Pace	ng, etc. (Specify)	airin, stre	set, lactory, o	IIICO			City or Tow	n, State)	iber or Run	17 Houle Nu	imber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier Certifyin	ng Physician: To the	best of my knowledg	je, death	occurred at t	the time	e, date and	d place,	and due to the o	ause(s) and n	nanner as s	stated.	
	he Ho in 24 he Fu pleteli	edical	(Check only 2 Medicel	Examiner: On the band man	asis of examination ar ner stated.	nd/or inv	estigation, in	my op	inion, deat	h occurr	ed at the time, o	date and place	, and due t	o the cause	o(s)
	To t To t	Σ	29b. Signature and type of certifie	١٢	-		29c. L	icense	number		1	29d. Date sign	ed (Month,	Day, Year)	
•	4		10/2	-			1	15	3 10	3		Janua	14 4	, 200	55
	I		30. Name and address of person Stephen Va	who completed caus	e of death (Item 23a)	(Type, I	Print)		R	.1	Rockui	1/2 N	10	2085	2_
	Sta	te	 Date filed (Month, Day, Year) 	32.	gistrar's Signature		CONT.	030	_ / - /	~					
	Registi		JAN 0	7 2005	gistrar's Signature	19	NO THE								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year Valentin Dambo Okito Omengulo Pene Mundala January 4, ам 2005 1:33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

69 Yrs Months Days Hours Min. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 69 Director 212-67-9690 14, 1935 Oniemba, D.R. Congo Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Democratic Republic of 9048 Piney Branch Road, #103 Itams 23a 20903 the Congo filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 10 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Democratic Republic of Elementary/Secondary (0-12) College (1-4or 5+) Military Officer Congo permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If item 27 is marked other
any injury or other traumatic annea 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Constantin Mundala Yema Dombo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shako O. Okito/ Son 9048 Piney Branch Road, #103, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 15 Kinshasa, Democratic 1 Burial 2 Cremation 3 Removal from State Gombe Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 20.05 Republic of the Congo 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc Will Elsone 500 University Blvd, W, Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner The law requires that the death certificate be executed nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 20 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 X No this pletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours a t ③Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) canne (01 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Washington Adventist Hospital Deanna Renee White, 7600 Carroll Avenue, Takoma Park, MD 20912 M.D. 31. Date filed (Month, Day, Year) 32 egistrar's Signatu State JAN 07 2005 Registrar

			State of Maryland / Department of Health and Men 1- State State State Certificate of Death	ntal Hygiena	6002	01791
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month Da		3. Time of Death 2245 M
0	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	40	County of Death	
	Funeral Director	2	Months Days Hours Min. (Date of Birth (Month, Day, Year,	St. Mary' 9 Birthp Coun 1968 Mic	S lace (State or Foreign try) higan
	yland low		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		11	0d. Inside City Limits
	the Mar 28a-f st	Director	Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code	10a C	itizen of What Coun	1 ☐ Yes 2 No
	ath with the Marylan 23a or 28a-f show	al Dir	40257 Dockser Drive 20659	Un	ited Stat	es
920	urs after des af', or items Exercirer ru	by Funeral	11. Marital Status 1 Married 2 Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Nover Married 2 Married 1 Nover Married 2 Nover Married	Yes or No- in, etc.)	14. Race - Americ Black, White, i Specify:	
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "naturaf", or items 23a or 28a-f show imatic event, the Medical Exercites mark by rediffed at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Project Manager		Kind of Business/Inc	
and 2	9	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir		n <i>Sumam</i> e)	
lary	2 should be and Mental Is marked or aumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip	
nore, N	l and lealth im 27 her tr		Thomas M. McLean-father 2543 Charter Oak Drive, 20a. Method of Disposition 1 Burial 2 (A Cremation 3 Removal from State 1 Donation 5 Other (Specify) 2543 Charter Oak Drive, 20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory 01-12-	20c. L	ocation - City or To	wn, State
Baltin	pernit. Pages 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Licensee M01391 Huntt Crematory 01-12- 22. Name and Address of Facility Huntt Funeral Home,		dorf, Mar x 156, Wa	20604
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the dise me, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistock, or heart failure. List only one cause on end line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	spiratory arrest,	2	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	icai				42
P.O. Box 6	o the Hospital or Attending Physician: The law requires that the death certifical thin 24 hours after death. o the Funeral Director: After this certificate has been signed by the attending phy ompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delive Month	ory Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to th	ne cause of death?
Vital Records,	: The law recate has bee	Completed		24a. Was an autopsy performed?	death?	psy findings available impletion of cause of 2 No
r Vita	Physician: The this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 DEFOutpatient 3 DOA Other: 4 Nursing Home	- T	6 ☐Other (Specify	1)
MCLEAN ivision of	nding Phy ith. : After thi e funeral (ation:	27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of Injury 4 Work? 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? M 1 Yes 2 No	. Describe how inju	ury occurred	
	To the Hospital or Attend within 24 hours after death To the Funeral Director; /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f.	Location (Street a City or Town, State	and Number or Rura te)	l Route Number,
ROBERT	To the Hospital within 24 hours of the Funeral completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause(s at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
R	vithin To the	Me	29b. Signature and title of certifier 29c. License number	29d. D.	ate signed (Month,	Day, Year)
МІСНА	\ a L-		50 was and anddress of person who completed cause of death (Item 23a) (Type, Print)	00	huary	6, 2003
MI	1)B 1() Sta	ite	31. Date filed (Month, Day, Year) 2005 32. Resistrar's Signature.	ys 17	05 pital	
	Regist	rar	JAN 1 @ 2005 Been B. Sparke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Florence Sophie MURRAY 13, January 2005 7:27 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 86 Yrs 135-12-9553 **Director** New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at by Funeral Director 1 ☑ Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 1183 Luther Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 executive secretary 0 mental health other traumatic avant. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 Is marked othen any Injury or other traumatic avant Be 18. Mother's Name (First, Middle, Maiden Sumame) Emmett Nordman Bertha Markel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Murray - son 3 Revmont Dr., Shrewsbury, N. J. 07102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/17/05 Hagerstown, Maryland 21. Signature of Funtial Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME anne 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHF Pnysician Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COPD Chionic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed chronic burial-transit HTN that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 1□ Yes 210 No Hospital or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be IN ROUTE TO 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify, 1 Yes 2 No W.C.HOSP Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? KING 28b. Time of 28d. Describe how injury occurred MAGERSTONA 1 Natural 5 Pending Injury death. investigation 1 🗌 Yes 2 Accident after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellil 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Fun 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature atitle of certifier 29d. Date signed (Month, Day, Year) D0062223.

Registrar

State

30. Name and ad

31. Date filed (Month, Day, Year) JAN 14

DIAJA

O

00

340-MILL STREET, HAGERSTOWN MP21740.

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Begistrar's Signature

PRAVEEN BOLARUM, MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 18, Day 2005 Year **Physician** Isabelle Nellie McBee 12:09 pm · /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Feb. 27, 1916 9. Birthplace (State or Foreign Funeral 1□ M 2/2/F Hours Min. Months Days Maryland 232 26 6665 88 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2☐No Funeral Director Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 222 Drexel Drive 21014 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. Be Completed by XXVidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Dawson Barnes Sina Ann Robinette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Doloris J. Pinckney 222 Drexel Drive, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State spohrs Crossroads Cemetery 1/21/20 Berkeley Springs, WV XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. agnature of Funeral Society Licenses M00522 95 Union Street, Berkeley Springs, WV 25411 23a. Part is Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician ALZHEIMER'S DISEASE WITH Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): VENOUS INSUPPICIENCY Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? HU PERTENSION 1 Yes 2 No 3 Probably 4 Unknown PERNICIOUS *NEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DEPRESSIAN 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760, within 24 hours e To the Funerel C completely filled

TSabell

State

Registrar

edicai

4 Homicide

(Check only

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO C. VALARBO, M.D. 1716 HAR FORD ROAD FALLSTON

MD 21049 Plasie St Spark

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DØØ16389 JANUARY 18, 2805

JAN 2 5 2005

		riease i	State of Maryland / Department		•	3
		For State Registrar	Ce	rtificate of Death	Reg	.n2005 01794
Physic		Decedent's Name (First, Middle, Last) Luther Edward No.	owlin, Jr.		2. Date of Death Month January	Day 2005 3. Time of Death 1:45P. M
/Medi Exami		4a. Facility Name (If not institution, give Manor Care of Silv		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
Funeral		5. Social Security Number 6. Sec	34 and -	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y June3, 1	
Director		Usual Residence of Decedent			June3,1	
e Marylar a-f ehow	ctor	Maryland Prince G	eorge's Beltsvil			10d. Inside City Limits 1 ☐ Yes 2 🐴No
1215-0036 within 72 hours after death with the Maryland ene. than "neturel; or items 23e or 28e-f ehow he Medical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number 4616 Garrett Avent	ue	10f. Zip Code 20705		o. Citizen of What Country? United States
or deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 od within 72 hours after gilene. er than "neturel", or if	d by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 TXYes 2 □ No	1 ☐ Yes 🎾 No Specify:		Specify: White
15-C	oletec	15. Decedent's Edu (Specify only highest grad	e completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 16	b. Kind of Business/Industry
212 d withi	omo	Elementary/Secondary (0-12)	College (1-4or 5+) Super			Peoples Drugstore
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "neturel; or items 23s or 28a-f ehow any Injury of wheter the marked other than "neturel" or items 23s or 28a-f ehow any Injury of the Maryland Evantinat must be notified at once.	To Be C	17. Father's Name (First, Middle, Last) Luther E. Nowlin,	Sr.	18. Mother's Name Blanche	(First, Middle, Ma Lewis	iden Surname)
and 2 shou salth and N n 27 is mail	_	19a. Informant's Name/Relationship (Ty Delores Irene Nowl.		ng Address (Street and Number or Rura Garrett Avenue Be		
Baltimore, M permit. Pages 1 and 3 Department of Health Importent: If item 27 any Injury grather tr once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	20b. Place of Dispo cometery, cref George Wa	esition (Name of practice) shington Cemetery	Date 20	c. Location - City or Town, State Adelphi, Maryland
Baltimore, permit. Pages 1 a Department of Hee Importent: If item any Injury grathe once.		21. Signature of Funeral Service Licenson				Home, P.A. ville, Maryland 20705
		23a. Part1. Enter the disease, or complete	tions that caused the death. Do not ent e cause on each line.	FOR THE ROUSE FOR THE ROUSE THE BOOK OF THE ROUSE THE RO	ad Bellsv or respiratory arrest	ville, Maryland 20705 Approximate
Physician		Immediate Cause (Final disease or condition resulting in death)	Malandi: /	ung (quicer		Interval Between Onset and Death
/Medical Examiner			ue to (or as a consequence of):	,		
P #5	iner	Sequentially list conditions, if any, leading to immediate cause. Entit Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
S, P.O. Box 68760, es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
68760, ifficate be ex g physicien as the burial	dical		1.			
Sox 6 Th certif	an/Me	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	Other (specify)		Month Day Year
ds, Puires that signed by d be deta	þ	Part II. Other significant conditions cor	atributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records, he law requires the has been signed age 2 should be a	letec				24a. Was an	24b. Were autopsy findings available
I Rec	Completed				autopsy performe	prior to completion of cause of
of Vital F Physician: Th this certificate	Be	25. Was case referred to medical examiner?	lospital:	26. Place of Death		
F S S S S S S S S S S S S S S S S S S S	on: To	27. Manner of Death	2 ER/Outpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	tt 3 DOA 4 Tursing Hor	ne 5 🗌 Residenc 28d. Describe how	e 6 Other (Specify) injury occurred
Division I or Attending after death. Director: After din by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str	M 1 Yes 2 No	29f Location (Street	et and Number or Rural Route Number,
Div	Certif	4 Homicide determined	building, etc. (Specify)	1	City or Town, S	Sta te)
Division (To the Hospitel or Attending F Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the within To the comp	W	29b. Signature and title of certifier 2	uny ymy MI	> 29c. License number D43260		Date signed (Month, Day, Year) nuary 5, 2005
10		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	•		
		Jenny Moy, M.D. 13	8952 Baltimore Avenu	e Laurel, Maryland	20707	
St Regist	ate rar	31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year)	32. Pagistrar's Signature	rade		

			1 - State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H	lealth and <mark>I</mark> D <i>eath</i>	Mental Hygie		01795
			Decedent's Name (First, Middle, Las	")				2. Date of Death		3. Time of Death
	Physici /Media			Billy	Foster Orr	Sr.		Month January	8, 2005	10:00a™
	Examir		4a. Facility Name (If not institution, give	street and number,)	4b. City, Town, or	Location of Death		4c. County of De	
			5017 Mallard Lane			Free	derick		Fred	erick
	Funeral		Social Security Number 6. Se		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. 8	irthplace (State or Foreign Country)
	Director		400-32-3647	¾ M 2□F	71 Yrs.	Worths Days	Flours Will).	Dec. 4,		ntucky
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	agation				10d. Inside City Limits
	shor	'n	,		Toc. Oily, Town of Ed	ocation				1 XYes 2 No
	Ne M	ecto	Maryland Freder	ick	Frederick					
	with the Den	ä	10e. Street and Number			10f. Zip Code		109	. Citizen of What C	Country?
	s 23	Funeral Director	5017 Mallard Lane	12. Was Decedent	Ever in H.S. 42		1703		nited Sta	
	Itam Itam	Ë	11. Marital Status 1 □ Never Married 2 【X Married	Armed Forces	?	Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)	Black, Wh	
36	Ir, or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-1 show he Medical Examinar must be notified at	ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	16	b. Kind of Busines	
15	n "ng	plet	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	during most of wor	king		
212	yiene giene r tha	Completed	11	College (1-4or	34)	Carpent	er		Contruc	tion
	fillac Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	
lar	ald be fenta rked ric ev	To B	Earl Foster Orr				Esta Mae	Berger		
Maryland	12 should be filad within 7 h and Mental Hygiene. 7 Is marked other than "I traumatic event, the Med	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili			ral Route Number, C	ity or Town, State,	Zip Code)
	alth a 27 ls		Patricia Ann Orr/	Wife	5017	Mallard L	ane, Fre	derick, Ma	aryland 2	21703
Baltimore,	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28e-1 show any njury or other traumatic event, the Madical Examinal must be notified at once.		20a. Method of Disposition		20b. Place of Dispo	Britain Committee Committe	7.3 (2.5)	274	c. Location - City o	
E	Page sent c nt: If		1 🖾 Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify		1		1	.2/2005 Ro	ckville.	Marv1and
E	mit. Dartm oorta / inju		21. Signature of Egneral Service Licens	600 , ,				P. A. Fur		
ä	Department of the series of th		Lodd 19	1 Km	$\frac{0}{2}$	11n L. Mo 6401 Ridg	e koad.	P. A. Fui Damascus,	neral Hom Maryland	ne L 20872
10	I STE		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lication at cause						Approximate Interval Between
	Physician		Immediate Cause (Final							Onset and Death
	/Medical		disease or condition resulting in death)	v	tive Heart	Fallure				years
	Examiner			Athoro	sclerotic H	leart Dig	9966			Vezes
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):	icare bis	-430			16 6 3
	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events	C.						
oʻ	an an	EX	resulting in death) Last	Due to (or as	a consequence of):					
8760,	te be ysicia ne bu	cai		d						
9										
Вох	The law requires that the death certific ate has been signed by the attending p cage 2 should be detached for use as	Physician/Me	23b. was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of de	elivery
	that the death ted by the atter detached for u	Sicia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a		Other (specify)			Month	Day Year
P.0	at the by the	hys	9 🗆 Unknown	3C Olikilowii						
	es that igned be de	by F	Part II. Other significant conditions co	ntributing to death I	out not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ord	w requir been si should	ed						1 🗆 Yes	2 □ No 3 □ F	Probably 4 @Unknown
Records,	law re as be 2 sh	Completed						24a. Was an	24b. Were a	autopsy findings available completion of cause of
m	Tha Ite h	E						autopsy performed 1 ☐ Yes 2 🗸	death?	
Vital		a)	25. Was ase referred to medical				26. Place of Dea	th (Check only one)		
f V	Physicien: this certific ral director,	To B	exantiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpaties	nt 3 DOA Othe	er: 4 🗆 Nursing H	ome A Residenc	e 6 □Other (Sp	ecity)
J of			27. Many er of Death	28a. Date of Inju	ury 28b. Time o	f 28c. Injury Work	at	28d. Describe how	injury occurred	
Division	Attending or death.	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		Yes 2 □ No			
<u> </u>	l or Attendatter death Director;	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Flace of III	jury - At home, farm, str tc. (Specily)	reet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Certification:	1	1				,	*	
	ospi hour uner uner		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, deat of examination and/or in	h occurred at the tim	ne, date and place	, and due to the caus	e(s) and manner a	is stated.
	the H iin 24 the F iplete	Medical	one)	and manner s	tated.					
	To the within To the comple	Z	29b. Signature and title of certifier	71		29c. License	r r	29d.	Date signed (Mon	ith, Day, Year)
	(=		MANGE	4	~~V)	D3	5164		January 1	10, 2005
	(4)		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type,	Print)				7.000 (4.000) 11 (14.00)
			Andrew Zarick MD	200	7th Street,	Frederic	k, Maryl	and 21701		
	Sta	ite	31. Date filed (Month, Day, Year)	005 32. Resist	rar's Signature	Somath !				

		artment of Health and Me rtificate of Death	ental Hygien Reg. N	2005 H 1 796
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physician /Medical	EVELYN W. PRESSMAN		JANUARY 5	, 2005 3:15 P M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	HOLY CROSS NURSING HOME	BURTONSVILLE		MONTGOMERY
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Year	Birthplace (State or Foreign Country)
Director	229-44-8811 86 Yrs. Usual Residence of Decedent		AUG 12, 1	918 MARYLAND
show ad all	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Man Persh itor	MARYLAND MONTGOMERY POTON	1AC		1, Yes 2 □ No
with the Mar or 28e-fs be rolling	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
23e rai D	8917 HARVEST SQUARE COURT	20854	UNI	TED STATES
ifter death viriteer must	Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
urs afte	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:
"naturel", allcal Eva	15. Decedent's Education 16a, Dece	edent's Usual Occupation	16b. I	WHITE Kind of Business/Industry
ed within 72 hor ygiene. er than "nature t, tre Medical	(Specify only highest grade completed) (Given life.) Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	g	,
od withir or than tre Ma		RETARY	U	. S. GOVERNMENT
be filed within 72 hours after death with the Maryland half Hygiene. A hours after death with the Maryland to their than 'naturel', or items 23e or 28e-1 show event, it a Madical Evartinar must be notified at Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	
y outd houtd I Men narke natic	JULIUS WEINSTEIN	ROSE		INGER
d 2 st d 2 st th and 7 Is n traum		ing Address (Street and Number or Rural		
Heeling Heeling	20a. Method of Disposition 20b. Place of Disp	HARVEST SQUARE COU		AC, MD 20854 Location - City or Town, State
ages and of ages	1 A Burial 2 Uremation 3 Hemovial from State	matory or other place) REW CEMETERY JAN 7		
mit. F Sartmo Sortar Sortar		NZANSKY-GOLDBERG M		
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiens. Important: If item 27 is marked other than "rany injury or other traumatic event, If a Media. To Be Comple	Janey My Joni	170 RUCKVILLE PIKE,	ROCKVILLI	E, MD 20852
NOT THE !!	23a. Part . Enter the dise i.e, or complications that caused the death. Do not er shock, or heart fillure. List only one cause on each line.			Approximate Interval Between
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/Medical Examiner	resulting in death) Due to (or as a consequence of):			
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nsit	Cause (Disease or injury			
be executed total and burial-transit	that initiated events c			
pring p	d			
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nat the death certification by the attending petached for use as Physician/Mec	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
the all the all hed for sici	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)		Month Day Year
that the de ted by the a detached by Physic	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
w requires that should be det		and the second s		Probably 4 ☑ Unknown
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stcian: The law requirestory, page 2 should			autopsy performed?	prior to completion of cause of death?
e C	25. Was case referred to medical	26. Place of Death	(Check only one)	o 1 Yes 2 No
Physicia this cer al direct	examiner? 1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	0.1		6 ☐Other (Specify)
Attending Physician: The adeath. ector: After this certificate his by the funeral director, page liffication: To Be Com	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year) 28b. Time (Month, Day Year) Injury		Bd. Describe how inju	
eath. or: A the tu	2 Accident investigation	M 1 Yes 2 No		
tel or Attending F is after death. al Director: After ed in by the tuners Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	Bf. Location (Street a City or Town, Stat	nd Number or Rural Route Number, le)
ppitel ours a ours a filled	29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	nd due to the causels	c) and manner as stated
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Hours after death. To the Funeral Director: The this certificate has been signed by the attending phys completely filled in by the tuneral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date an	nd place, and due to the cause(s)
To the Hospitel or Attendi within 24 hours after death, to the Funeral Director; be completely filled in by the ta	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
1/	Fare pt	1043237	JANU	ARY 6, 2005
4	30. Name and address of person who completed cause of death (Item 23a) (Type			
	PAUL ARMSTRONG, M.D., 14201 LAUREL PA		J2 LAUREI	L, MD 20707
State Registrar	31. Date filed (Month, Day, Year) JAN 1 0 2005 32. Jegistrar's Signature	arti		

		For	State	of Maryl	land / Dep	artment of I	Health ar	nd Mental F	lygien	e o o	·	1 7 0 7
		1 - Stata Registrar			Ce	rtificate of	Death		Reg. N	<u> </u>	5 U	1/9/
Physici	an	Decedent's Name (First, Middle						2. Date of Month	-	ay Ye	ear	Time of Death
/Media	cal	Raymond Josep						Janua				:05 а м
Examir	ner	4a. Facility Name (If not institution				4b. City, Town,			4	c. County of		
Function		Bedford Court 5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Year	er Spri		Rinth	Montg		State or Foreign
Funeral Director		322-07-6493	1 X □M 2□F	91	Yrs.	Months Days		Min. (Month,	Day, Year 20, 19		Country)	State or Foreign
D		Usual Residence of Decedent						J Ouric	20, 13	13		713
arylar show	Ļ	10a. State 10b. County		100	. City, Town or L	ocation						side City Limits
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death with the Maryland ms 23a or 28a-f show Emust be notified at	Funerai	3701 Internati		cedent Ever		2090		2 (Specify Ves or	No.		USA American Inc	tion
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aryid should I ind Men marke umaric	ř	19a. Informant's Name/Relations			19b. Maili	na Address (Street		or Rural Route Nur	_	or Town Sta	te Zin Code)
paritimiore, interview A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exemples must be notified at once.		_Anne Marie Pro						A000 000 000 000 000 000 000 000 000 00			100000000000000000000000000000000000000	
Item Stan		20a. Method of Disposition	•		b. Place of Dispo	Internation (Name of matory or other pla		Dr, Silv Date uary 7,		or 1113, ocation - City	y or Town, St	tate
mit. Pages partment of it portant: if Its y Injury or g		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S			-	an Cremato	. 4 411	2005	A 1 e	-xandr	ia: Vi	rginia
Dall permit. Departr Importa any Inji		21. Signature of Funeral Service	Licensee	*	P F	Name and Addre	ess of Facility					
0 88E 28		Morred 1	18yu					ns Funer		er Spr	ing,MD	20901
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attence for us	ian/	23b. Was decedent pregnant in the past 12 months?		birth 2 F	etal death 3	Ectopic pregnanc	у			23d. Date of Month	delivery Day	Year
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ding f	lon	27. Manner of Death ★★Natural 5 ☐ Pendin	9	nth, Day Year	r) 28b. Time of Injury	Wo		28d. Describ	e how inju	ry occurred		
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 (S Certifyin (Check only 2 Madical	g Physician: To th	e best of my	knowledge, deatl	occurred at the til	me, date and p	lace, and due to the	ne cause(s) and manne	r as stated.	
the H iin 24 the F	Medical	one,		nner stated.	nination and/or in			occurred at the tim	e, date an	d place, and	due to the ca	iuse(s)
To To	2	29b. Signature and title of certifier	50)_		29c. Licens	se number D3084	Δ		te signed (M		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 15 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day G Month **Physician** Gertrude E. Poffenberger January 2005 4:18 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5021 Avoca Avenue Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 TF 214 26 6784 87 Feb 23, 1917 Pennsylvania Director Usual Residence of Decedent deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes & No Director Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or 5021 Avoca Avenue 21043 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item eny injury or other traumatic event, the Medical Enantment page. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bottle Decorator Glass Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin S. Row Katie R. Shoffstall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin L. Poffenberger/Son 2408 Chesnut Terrace Ct. #303 Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 1-13-2005 Glen Burnie, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 With 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks disease or condition resulting in death) an Go /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending within 24 hours after co...
To the Funeral Director: After managed filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 405/9 1-10-05 all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Colon Burne, 2106, MIRL M. NOSCITOR 1401 Madison 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 1 2005 Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of	Maryland		rtment tificate			and Me	_	giene Reg. No.	005		179	99
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	Physicia /Medic	al -	Hildegard Prama								January			N= = 415	2:30	
	Examin	er	4a. Fecility Name (If not institution				,.		Location o	of Death			County of D		-	
			Anne Arundel Mo		ter . Age (In yrs. last	birthday)	Annar		S If Under 2	24 Hrs.	3. Date of Bir		ne Aru			r Foreian
	Funeral Director		040-28-7939	1 □ M 2 💢 F	83	Yrs.		Days	Hours	Min.	(Month, Da)4/13/	v. Year)		Countr	nce (State o. ry) n v	
			Usual Residence of Decedent								,,,,,,,					
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ဗ္ဗ	within 72 hours after death with the Maryland ene. Itan "naturaf", or items 23a or 28a-f show Ita Modical Exprimer most be notified at	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dai	les:		1 ☐ Yes 2	LALNO _	Specify:				Specify:	Whi	te	
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5	filed v Hygie ther t int, to		17. Father's Name (First, Middle,	5_+			ACCOL	IIILa			(First, Middle			TIIR		
Maryland	ld be ental ked o	To Be	Joseph Vorreit	er					Jose	pha S	Schmid	t				
ary	shou ind M s mar umat		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rural	Route Numb	er, City o	or Town, Sta	te, Zip (Code)	
Σ	and 2		Sylvia Zborowsk	i/ Daughte					e Cou		owie, l					
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from S	cem	e of Dispo etery, crei	sition (Nam matory or of	ne of ther place			ate		ocation - City			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show important: if item 27 is marked other than "natural; or items 23a or 28a-f show important: it items 27 is marked other than 2000.		21. Signature of Funeral Service	engee							ert E. 1 Bowie					е
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			shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ich line				3,		,				Interval Bet Onset and I	ween Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (c	m phys	ce of):	CA							-		
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Ш	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequer	nce of):										
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequer	200 06):								_		
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Box (death certificate e attending phys d for use as the	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	come of pregnanc		7e						23d. Date o	f deliver	У	
		lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 ☐ Fetal de ant at time of deat		□Ectopic pr □ Other (sp						Month	1	Day '	Year
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ord	w requir been si should	eted										_				
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jo	Attending I r death. ector: After by the funer	atlo	Z	igation	,,	,,	М		Yes 2 🗆							
Division		Certification:	3 Suicide 6 Could 4 Homicide determ	nined 288. Place	of Injury - At homing, etc. (Specify)	e, farm, st	reet, factory	, office		2	8f. Location City or To			or Rural	Route Num	iber,
	Hospital (24 hours al Funeral D		29a. Certifier 1 Certifyi	ng Physicien: To the	heat of my knowl	odgo des	th occurred	at the tin	ne date a	nd place a	and due to the	caucale	and mann	or se et	ated	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical one)	Examiner: On the ba	sis of examinatio	n and/or ir	rvestigation	, in my o	pinion, dea	ath occurre	ed at the time	, date an	d place, and	due to	the cause(s	;)
	To the within 2 To the complet	ž	29b. Signature and title of certific	er ///	110		290	c. Licens	e number	1 -1		29d. Da	ate signed (/	yonth, L	Day, Year)	
,			flow	1/2	MD		P	77	10	1		1	16/	05	•	
			30. Name and address of person	who completed caus	e of death (Item 2	3a) (Type	, Print)	A		A	10	1	11	1	C.	10.
	St	ate	31. Date filed (Month, Day, Year		gistrar's Signatu	ге	1 .	11	y we	1 /4	and Old		100/0	c 21	0 -	1,0
	Regist		JAN 0	7 2005	Som I	5 1	Spools.	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 25 per doc 8845 7-21-05 vt.
State of Maryland / Department of Health and Mental Hygiemen 65

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year LOUISE PURNELL FLLA **JANUARY 1, 2005** 4:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Nursing and Rehab Center Wicomico Salisbury, Md. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🖾 F 109-26-7715 94 Yrs. Director August 25, 1910 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County r then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e, Street and Number 40f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a any injury or other treumatic event, the Medical Examiner mass 200. 511 Collins Street 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic 5th laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Winder Lucy Jones ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everette Waller, Jr./ son 511 Collins Street - Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2
☐ Cremation 3
☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem. Pk | 01/08/2005 Salisbury, Maryland 21. Sign turn of Funeral Service Lice s -22. Name and Address of Facility 213 Jersey RD - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) **Physician** e an /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed -transit physician ar Due to (or as a consequence of) Physician/Medical as attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 DUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 1 No 2 No 1 🗆 Yes 1 ☐ Yes To the Hospitel or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 🏖 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 Homicide hours after within 24 hours a To the Funerel (1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Robins, 200 Civic Ave., Salisbury, Md. 21804 MID 31. Date filed (Month, Day, 32. Pgistrar's Signature 1 1 2005 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Vital Records, P.O. Box 68760

ELLA L. PURNELL

		•	State of Maryland / Department of Health 1- State Registrar Certificate of Death		tal Hygiei Reg.	2005	01801
			Decedent's Name (First, Middle, Last)	2. D	ate of Death		3. Time of Death
	Physicia		Beatrice S. Roland	_	Month Inuary '	Day Year 7, 2005	11:41 ^p ^M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location			4c. County of Dea	
			9505 Pin Oak Drive Silver Spri	ing		Montgon	nery
	Funeral			or 24 Hrs. 8. D	ate of Birth Month, Day, Ye	9. Bir	thplace (State or Foreign
	Director		578-20-3404 84 ^{Yrs.}		ril 18,	1	shington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f eho	ö	Maryland Montgomery Silver Spring				1 ☐ Yes 21 No
	the 1	Directo	10e. Street and Number 10f. Zip Code		10a.	Citizen of What Co	ountry?
	3a or	<u> </u>	9505 Pin Oak Drive 20910		-3	USA	,
	death ma 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	origin? (Specify)	Yes or No-	14. Race - Ame	
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Itema 23a or 28a-f ehow many injury go other traumetic event, the Medical Evantinar must be notified at once.	ρ	Armed Forces? If Yes, specify Cuban, Mexica 1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No Specify 3 □ Widowed 4 □ Divorced Year or Dates:		n, etc.)	Black, Whit Specify: Whi	
2-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during mo life. DO NOT use retired)	ost of working	16b	. Kind of Business	/Industry
7 7	d withingiane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper		Αι	utomobile	Dealership
2	al Hy al Hy d othe	Be (17. Father's Name (First, Middle, Last) 18. Moth	her's Name (Firs	st, Middle, Maid	den Sumame)	
ylan	Ment Ment arked etic	To	Cleveland Skinker V	/iola Gr	aham		
Mar	2 sho and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb				
≥ ຄົ	and lealth im 27 her t	1	Joseph W. Roland/Husband 9505 Pin Oak Driv 20a Method of Disposition 20b. Place of Disposition (Name of	e, Silv			
Baltimore,	Pages nent of h ant: if its		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State, '4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery	January 2005	14	. Location - City or ashington	
Bail	permit. Depertr Importe any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Faci Francis J. Co 500 University	ollins F	uneral W, Silv	Home Inc	: a. MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.				Approximate Interval Between
1	Physician		Immediate Cause (Final disease or conditiona_ Pulmonary Metastasis				Onset and Death
	/Medical		resulting in death) a. Tarking factors a consequence of):				1 Month
	Examiner		Sequentially list conditions b. Metastatic Colon Cancer				3 Months
	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	end end i-tran	Examine	resulting in death) Last Due to (or as a consequence of):				
o e	ificate be executed g physician end as the burial-transit	icai E					
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Xon	certii nding use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery
	at the death certifi I by the attending parached for use as	ician/M	In the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
j.	t the by the ache	hysi	9 ☐ Unknown				
رن ح	igned be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I. 2	23e. Did tobac	co use contribute to	the cause of death?
ğ	w require been si should b	ed	Anemia, Coronary Artery Disease		1 🗌 Yes	2 No 3 P	robably 4 💢nknown
ပ္မ	law requires that the as been signed by th 2 should be detache	ompieted		2	24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
ř	The ate h page	Com		1	performed Yes 2☐	? death?	2 No
Vital Records,	Physician: The law this certificate has ral director, page 2 s	Be (25. Was case referred to medical examiner?	ce of Death (Chi			
0	Physis this o	<u>o</u>	1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ N			6 Other (Spe	ocify)
Ĕ	ding P. h. After i	lon:	27. Manner of Death 1 StNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Nork?		Describe how in	njury occurred	
<u>s</u>	Attendi death. ctor: A y the fu	icat	2 Accident investigation M 1 Yes 2 3 Suicide 6 Could not be		postion /Stran	t and Number or P	ural Route Number.
Division	ire in	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	201. [City or Town, S	tate)	urai noute Numper,
	e Hospital of 24 hours at the Funeral Dietely filled it		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and d	lue to the cause	e(s) and manner as	s stated.
	To the Hosp within 24 ho To the Func completely t	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	eath occurred at	the time, date	and place, and due	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number	r	29d.	Date signed (Mont	
			June M Janellona D35996			January	10, 2005
	4-19 49		Anne and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burell, M.D. 2730 University Blvd, #40	O. Whea	ton Mr	20902	
	Sta	te		o, mied	JOII, III	20302	
	Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature Apacle 33. Date filed (Month, Day, Year)				

			1 - For State Registrar	State of M	Maryland 		artment of rtificate of		and M		jiene leg. Nő.	005	01802
ı	Physici	an	Decedent's Name (First, Middle, La James K	•	R	itten	house			2. Date of Dea Month January	Day	2005	3. Time of Death 3:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give			100011	4b. City, Town,	or Location o		Januar	1	County of De	
ı		•	Fairland Adventi	st Nursin	g & Re	hab.	Silve	r Spri	ng			Montg	omerv
	Funeral Director		5. Social Security Number 6. S		Age (In yrs. la: 82	st birthday)	If Under 1 Year Months Days	r If Under 2	24 Hrs.	8. Date of Birth (Month, Day March 2	Year)	9. B	irthplace (State or Foreign Country)
	0		Usual Residence of Decedent		- 02			1 1		daren 2	ο, Ι	.922 _V	irginia
	anylan show det	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	the Ma	Directo	Virginia Oran	ge	Lo	cust (1 ☐ Yes 2 🖾 No
	with 3a or		2105 Kings Cour	+			10f. Zip Code 225	00			log. Citia	zen of What C	Country?
	death	Funerai	11. Marital Status	12. Was Decede			Was Decedent of	Hispanic Orio	gin? (Spec	ify Yes or No-	1		nerican Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ TWidowed 4 ☐ Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date:	□ No		f Yes, specify Cui 1 □ Yes 21□ No		, Puerto F	fican, etc.)		Black, Wh Specify: WI	
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פַ	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,			JIIICS
y a	Menta Menta arked	To E	John James Rit	tenhouse				Cla	udia	Ball			
Maryland	12 should hand 7 is m.		19a. Informant's Name/Relationship (Type, Print)			ng Address (Stree						
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Ē	Pages ent of nt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		" Gate	e of F	natory`or other pla Heaven	^{зсө)} ¦Ј	anuai 200!	ry 10,			ing, Marylan
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	RPark	21	emeter Fi	Name and Addr	ess of Facility COII	ins I	Funeral	Hom	e Inc	ng, MD 20901
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VItal	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?			-			of Death	(Check only on			
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	To the Hospital or Attendin, within 24 hours after death, To the Funeral Director: After completely filled in by the fun	edicai	29a. Certifier 1 ← Certifying Pt (Check only one) 2 ☐ Medical Exar	nysician: To the best niner: On the basis and manner	or examinatio	edge, death n and/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, an	nd due to the ca d at the time, d	ause(s) a ate and	and manner a place, and du	s stated. e to the cause(s)
	vith To t	Σ	29b. Signature and title of certifier	a O				se number 058962		2	9d. Date	signed (Mon	th, Day, Year)
	41		Y X V V	~								Januar	y 7, 2005
	-(1 '		30. Name and address of person who				Print) Cove Road	4 #300	n =-	+ho~3-	R# IT	20050	
	Sta		Shashank G. Pate 31. Date filed (Month, Day, Year)	32. Pegis	strar's Signatur	re /	ade)	., #3U(<i>,</i> ве	chesda	, MD	20850	
	Registr	ar	JAN 10 2	005 3	strar's Signatur	19	200						

			1 - For State Registrar	State of Maryland		rtment				Re	g. No. U	5	0180)3
	Physici	an	Decedent's Name (First, Middle, Las John LeMoyne Ran	,						2. Date of Death Month	Day	Year	3. Time of	Death P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, 1		Location o	f Death	January	4c. County	of Death	9:05 Arundel	
	Funeral Director		5. Social Security Number 6. Security Number 218–26–3675	7. Age (In yrs. Ia 32M 2 F 80	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Aug. 21	, 1924	9. Birth Cou Ma:	place (State o intry) ryland	r Foreign
	the Maryland 28a-f show cyliffed at	tor	10a. State 10b. County Maryland Anne Ar		Town or Loc	cation	Ar	napo.	lis				10d. Inside Cit	•
	th with the 23a or 28	Funeral Director	10e. Street and Number 1610 Knoll Driv	e		10f. Zip		1401		10	g. Citizen of V	What Cou	intry?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Evarians from the conflict of an once.	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Myes 2 ☐ No If Yes, Give Year or Dates: 1943-	1	Vas Decede Yes, speci		spanic Origin, Mexican Specify:	gin? (Spec , Puerto Ri	fy Yes or No- can, etc.)		ck, White	ican Indian, , etc. White	
21215-0036	ithin 72 h ne. nen "natu	Completed	15. Decedent's Ed (Specify only highest gra-			kind of worl OO NOT us	k done di e retired)	uring most	of working	7	6b. Kind of B		•	
	id be filed wental Hygier ked other ti ic event, the	To Be Co	12 17. Father's Name (First, Middle, Last) Blanchard Randa		Ma	nufac		18. Mothe		First, Middle, M	laiden Suman		roducts	
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8760,	cate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseque	ence of):									
O. Box 68	ath certifi attending for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal c 4 Pregnant at time of dea	teath 3 🗌	Ectopic pre						te of deliventh	,	'ear
rds, P.	w requires that the de been signed by the s should be detached		Part II. Other significant conditions or	ontributing to death but not result	ting in the un	iderlying ca	use give	n in Part I.		23e. Did toba	1/	ribute to	the cause of debathy 4 🔲	eath? Inknown
I Records,	The law recate has bee page 2 shot	Completed by								24a. Was an autopsy perform	ed?	Were autoprior to co death?	opsy findings a ompletion of ca	ivailable
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:					of Death (Check only one				
of	Phys this cral dir	To.	1 Yes 22 No 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 28b. Time of			4 🔲 1101	rsing Home	5 Desider	nce 6 Oth		fy)	
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year)	Injury	М		?" es 2□N	No	f. Location (Stre City or Town,	eet and Numb		al Route Numb	ber,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier Check only one) Certifying Physical Example 1	/sician: To the best of my know iner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred a estigation,	it the time in my opi	e, date and inion, deat	d place, and h occurred	d due to the car at the time, da	use(s) and ma te and place,	inner as s and due t	stated. o the cause(s)	
	To th withir To th compl	Me	29b. Signature and title of certifier	Mw		29c.	License	number 5 1 3	01	29 E1	d. Date signed	d (Month,	Day, Year)	
_			30. Name and address of person who describes the second se	ompleted cause of death (Item 2	23a) (Type, F	Print)	oud.	sute	300	Annap	olis N	102	1401	
	Sta Registr		31. Date filed (Month, Day, Year).	32. Figistrar's Signatu	TO A	Good .				/	/		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiène OF

			For State of Marylan 1 - State Registrar		ertificate of t			giene Reg. No.		01804
	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of De. Month	ath Day		3. Time of Death A
	/Medic	al	john Louis Ronzo 4a. Facility Name (If not institution, give street and number)		45 City Tayon o		Januar		County of Deat	0655 M
	Examin	er				Location of Death				
	Funeral		Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. 1 M 2□ F 62		Hagers If Under T Year Months Days	If Under 24 Hrs. 1 Hours Min.	B. Date of Bird	th Year)	9. Bin	n County hplace (State or Foreign
	Director		154-32-1397	Yrs.	Months Days	Hours Will.	B. Date of Bird (Month, Da Oct 2	3 19	42 New	Jersey
	land		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or L	ocation					10d. Inside City Limits
	with the Maryland a or 28a-f show the notified at	ţō	Maryland Washington	Hager:	stown					1 □Yes 2 No
	th the or 28s	irec	10e. Street and Number		10f. Zip Code			10g. Cit	izen of What Co	untry?
	death with the Maryland ms 23a or 28a-f show	ral	20529 Bluebird Ave.		21742				mited S	
036	9 E E	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Agried Forces? 14. Yes, Give Year or Dates:	.S. 13	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No ican, etc.)		14. Race - Ame Black, Whit Whit Specify:	
5-0	72 hour natural	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Dec (Giv	edent's Usual Occup	ation during most of working d)	g	16b. K	ind of Business/	Industry
12.	y withir gene. r than	Completed	Elementary/Secondary (0·12) College (1-4or 5+)		chinest	-//		נ וייינון)	ck Manu	facture
2	be filed with tal Hygiene d other tha event, Ira	Be C	17. Father's Name (First, Middle, Last)	I PRO	CITTIEST	18. Mother's Name	(First, Middle,			caccarc
Var	2 should be filed vogential Hygie Is marked other traumatic event.	ToE	Louis Peter Ronzo						Scerra	
Za Z	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural				
نه	1 and Health em 27 thar t		Carol Ann Ronzo (wife) 20a. Method of Disposition 20b. F	205. Place of Disp	29 Bluebia position (Name of	rd Ave. Had	gersto	wn N. 20c. Lo	aryland ocation - City or	21742 Town, State
Baltimore. Marvland 21215-0036	Pages ment of ant: If it ury or o		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify)	est Ha	ematory or other place ven Cemete	:A1 '				Maryland
Balt	permit. Pages 1 and 2 Department of Heaith a Important: If item 27 is any injury or othar tra		21. Signature of Funeral Service Licensee		22. Na <i>m</i> e and Addre	Dou				eral Home yland 21742
			23a. Part1. Enter the disease, or complications that caused the deal shock, or hear failure. List only one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	na ti	en.					Onset and Death
	/Medical Examiner		Due to (or as consec	quence o):	Low	La se versionale ac				
		Je.	Sequentially list conditions, if any, leading to immediate	dneuce oth:	ne ne m	orrage				
~	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to infiniediate cause. Einer Underlying Cause (Disease or injury that initiated events	ma						
7	e exe sian ar urial-t	EX	resulting in death) Last Due (o (or as a consec	quence of):						
Till 1	icate be executed physician and s the burial-transit	ledicai	d							
_	eath certiff attending for use as		IF FEMALE: 23c. If yes, outcome of pregnant		- vv				23d. Date of del	ivery
as is	Attending Physician: The law requires that the death certificate be executed to death. The death certificate has been signed by the attending physician and ector: Affer this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	in the past 12 months? 1 Yes 2 No		Cther (specify)	y			Month	Day Year
	that the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not res	sulting in the	underlying cause giv	ren in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
Vital Records	quires tha	ed by	Chronic renal failus	ر عا			1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown
W) 0	law requir as been s 2 should	piet	<u> </u>				24a. Was		24b. Were au	itopsy findings available completion of cause of
to ME	The ate has page	Com						rmed? 2 X No	death?	2 No
1 Sita	iclan: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?		Ott	26. Place of Death				
2 50	Physic r this c	5	1 Yes 2 XNo 1703priant 2 2 27. Manner of Death 28a. Date of Injury	ER/Outpati 28b. Time		4 🗆 Nul Sing Hoth	e 5 🗆 Resi			cify)
mand sion of	ding th. : After	tion	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Wor	rk? Yes 2 □ No			,	
Jaked Division of	r Atter	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Speci		street, factory, office	2	Bf. Location (City or To	Street ar	nd Number or Ru	ural Route Number,
Ċ	oital or urs aft ral DI									
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kni (Check only one) 1 Midical Examiner: On the basis of examination and magner stated.							
	To the within To the comp	M	29b. Signature and the of certifier	67	29c. Licens	se number		29d. Da	ite signed (Mont	h, Day, Year)
			30. Name and address in person who completed cause of death (It/	23a) (Typ	e, Print)	U 1 15	71		-12-0	5
0	7H-8+1		Dr Neuman 11110	Med	1	mpus	15-7	1+1-	1. MJ	21742
	Sta Regist		31. Date filed (Month, Pay, Year) JAN 14 2005 32. Begistrar's Sign	S. A	pule	<i>V</i>			1	

1 - For State Registrar

10a State

5. Social Security Number

174-36-4877 Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Lee

10b. County

4affacility Name (If not institution, give street and number)

6. Sex

1**⊠** M 2□ F

Stewart

Modicios Center

7. Age (In yrs. last birthday,

60

Yrs.

10c. City, Town or Location

nours arier deem with the warylar lural', or itema 23a or 28a-f show al Examiner must be notified at	<u>.</u>	10a. State 10b. County		10c. City, Tow	vn or Loca	ation				10d. Inside City Limit
or 28a-f sho	Director	Delaware Susse	X	Delma	ar					1 □ Yes 2 No
or 2		10e. Street and Number				10f. Zip Code		10g. (Citizen of What C	ountry?
and a should be lined within 72 hours after deem with feath and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a other traumatic event, the Medical Examiner must be other traumatic event, the Medical Examiner must be seen to the contract of the contr	rai	12884 Oak Branc			_,	19940		US		
or itema	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?)	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi	
i o	<u>Y</u>	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	10	□Yes 2X No	Specify:		Specify:	
"natural",			Year or Dates:	10-	December	-11-11			W	nite
adia a	Completed	15. Decedent' (Specify only highest	grade completed)	16a	(Give ki	nt's Usual Occupa ind of work done of DNOT use retired	during most of working	16b.	Kind of Business	/Industry
other than	립	Elementary/Secondary (0-12)	College (1-4or				1)	Ma		- d t-
other ant, it		17. Father's Name (First, Middle, L	ast)	Pa	irts	Manager	18. Molher's Name (F		arine Equ	11pment
aumatic eve	Be							irst, ivilouie, ivialor	_	
) Pari	ပို	Charles 19a. Informant's Name/Relationsh	Stewa Scient		- Mailin-	Address (Obrest)	Hazel		Conno	
trau				1000			and Number or Rural R	1977		Zip Code)
other tre		<u>Candida Stewart</u> 20a. Method of Disposition	(wife)	20h Place o	2884	Oak Bran	nch Road, D			19940
= 5		1 🗆 Burial 2 🗷 Cremation		cemete	ry, crema	itory or other plac	ea)	200.	Location - City or	Town, State
in ei		`4 □ Donation 5 □ Other (Sp		Salisk	oury	Cremator	cy January 10), 2005 Sa	alisbury, N	/aryland
any in		21 Signature / Furteral Service L	icensee		HC	Name and Address	ss of Facility Tuneral Hom	e Profes	sional A	Association
= 6 O	Щ	David H.	dompon	>, CFSF	2 50	1 Chart I	Hill Dood	Calichur	y, Mary]	land 21804
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complication that caused the thing one cause on each li	the death. Do	not enter	the mode of dyin	g, such as cardiac or re	spiratory arrest,	4	Approximate Interval Between
ician		Immediate Cause (Final disease or condition	(dea	and to	Ru.	01.1	1200			Onset and Death
dical		resulting in death)	aDue to (or as	a consequence	of):	as for				(ears
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	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):	- Jiwi i C		(100 0) 17	7 5.00 (1.0)	/
ansit	声	Cause (Disease or injury that initiated events	ha	Munks	Stand					V20-00
<u>w</u>	Examiner	resulting in death) Last	Due to (or as	a consequence	of):	James				Years Vans
a bur	Sa		la Re	nal T	12	norta	nf.			Year
signed by the attending physicien and I be detached for use as the burial-transit	edic									
nse s	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d. Date of de	livery
for	ciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death time of death		ctopic pregnancy Other (specify)			Month	Day Year
L. In	Jysi	9 Unknown	9□ Unknown							
deta	2	Part II. Dther significant condition	s contributing to death b	ut not resulting in	n the und	erlying cause give	en in Part I.	23e. Did tobacco	use contribute to	o lhe cause of death?
5	Completed by							1 🗆 Yes	2 €No 3 □ Pi	robably 4 Unknown
should	ete									
22	μ							24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ctor, page 2 s	Ö							performe	death?	20 No
· m	Be	25. Was case referred to medical examiner?					26. Place of Death C			
dir	ို	1 Yes 2 No		ent 2 ER/Ou	utpatient	3□ DOA Othe	er: 4 🗆 Nursing Home	5 🗆 Residence	6 □Other (Spe	cify)
Inera	ä	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. 7	Time of Injury	28c. Injury Work	at 28d.	Describe how inj		
	ati	2 ☐ Accident investiga	ition			M 1 1	Yes 2□No			
by	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injuding, etc	ury - At home, fa	arm, stree	t, factory, office	28f.	Location (Street a		ural Route Number,
ed in	Ş			(,,		
ly fill		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge	e, death o	ccurred at the tim	e, date and place, and	due to the cause(s) and manner as	stated.
olete	Medical	one)	xaminer: On the basis of and manner sta	r examination an ated.	id/or inve	stigation, in my op	onion, death occurred a	it the lime, date ar	nd place, and due	to the cause(s)
completely filled in by the funer	Σ	29b. Signature and title of certifier				29c. License	number	29d. D	ate signed (Monta	h, Day, Year)
		1 temanil	1 agle ,	nus		000	1/211	1	18/05	
1		30. Name and address of person w	to completed cause of d	eath (Item 23a)	(Type Pr	int)	(1 0.1		3/02	
7		Fernando	J. Acla	MD		O Carr	oll 57 3	Salisba.	MI). 21801
Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	, ,	311	011 01 0	J-6123 CG1	5,114	01001
egistra		JAN 1 1	2005	ar's Signature	2			-		
17 Rev 1/20			. 2003	ne St	190	2163				
/ NOV 1/20	U I									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5

4b. City, Town, or Location of Death

2. Date of Death

8. Date of Birth (Month, Day, Ye January 4,

ANUARY 8 2005

Month

3. Time of Death

Birthplace (State or Foreign Country)

Pennsylvania

1950 M

Year

Wicruce

4c. County of Death-

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 115 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 January Margaret Foglesanger Schultz 8:40 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Washington County Homewood Retirement Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 82 Director 19 1922 Maryland 220-18-0455 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at XXYes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or Items 23a United States 21742 238 Potomac Heights 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Spacify: White Baltimore, Maryland 21215-0036 1 Yes 2 No <u>م</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 6 School Teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harper Foglesanger Effie Belle Sites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau once. Randall I. Schultz (Son) 100 Calvert Terrace Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 1-14-05 Smithsburg Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd, N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final Provsician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No SE No 1 Yes 1 Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certification 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2005 Registrar

			1 - For State Registrar	State of M	laryland /	-	ertment of H tificate of L		Mental Hyg	iene g. No.2 0 0	5	018	307
ď			Decedent's Name (First, Middle, Last)						2. Date of Deat	h		3. Time of	Death
	Physici /Medio		Sallie Loven Su	mmers					January	10 20	05	10:30	AM
	Examin		4a. Facility Name (If not institution, give s	street and number	-)		4b. City, Town, or	Location of Dea	ath	4c. County of	Death		
			Avalon Manor He	alth Car	e Cente	r	Hagers	town		Washin	gton	Coun	ty
	Funeral Director		5. Social Security Number 6. Sex 215–20–8707	7. A	ge (In yrs. last I 96	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		^{Year)} 1908	. Birthplac Country Virg	e (State o	r Foreign
_	D .		Usual Residence of Decedent		1.00								
	anyla shov	-	10a. State 10b. County		10c. City, To						100	. Inside Cit 1 ☐ Yes	· V
	the N 28e-f	Director	Maryland Washing 10e. Street and Number	ton	На	gers	10f. Zip Code			0g. Citizen of Wha	at Countr		
	with		14014 Marsh Pike				2174	2		United S			
	Jeath The 23	Funeral		12. Was Deceden	t Ever in U.S.	13. \			Specify Yes or No- irto Rican, etc.)	14. Race -	American	Indian,	
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Beginner of Heath and Mental Hygiene. Beginner of the traumatic event, Ital Modical Evaluing must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 24 If Yes, Give Year or Dates:	No		Yes, specify Cuba	n, Mexican, Pue Specify:	rto Rican, etc.)	Black, Specify:	White, etc Blac		
2-C	2 hou		15. Decedent's Educ		16	a. Deced	ent's Usual Occupa	ition	7.	16b. Kind of Busir	ness/Indus	stry	
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and	be file tat Hy d oth event	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle, M	feiden Surname)			
ya	Men	2	James Daniel Jon						e Rucker				
<u>a</u>	12 sh hand 7 is m raum		19a. Informant's Name/Relationship (Ty)	·	. 1		200 mm		Rural Route Number,	1576			_
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פֿ	ages nt of l t: If it		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cemer	tery, cren	Cemetery			Sharpsbu			ha
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١,			23a. Part1. Enter the disease, or complishock, or head failure. List only on Immediate Cause (Final	cations that cause le cause on each	ed the death. De	o not ente	er the mode of dying	, such as cardi	. N. Hage ac or respiratory arre	est,	A. In	pproximate iterval Betv nset and D	e ween
Ι.	Inysician /Medical		disease or condition resulting in death)	Due to lor a	s a consequenc	e of):	Candia	war set	les of	rene	-	387	2
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	cate be executed physician and : the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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0/0	cate be execu physician and the burial-trar	dicai											
) K	ertific ding p	/Mec	IF FEMALE:	2a If was autaom	o of prognance								
YOU O	aath c attend for us	Physician/Me	in the past 12 months?		e of pregnancy 2 ☐ Fetal dea at time of death		Ectopic pregnancy			23d. Date o Month	,	ıy Y	'ear
j	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time or death	5∟	Other (specify)						
Ĺ	that the ed by deta		Part II. Other significant conditions con	tributing to death	but not resulting	in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribu	ite to the o	ause of de	eath?
cords,	The law requires that the death certifi are has been signed by the attending page 2 should be detached for use as	ed by							1 ☐ Ye	s 2□No 3[] Probabl	y 4 120	nknown
2	awre s bec 2 sho	Completed							24a. Was ar		e autopsy	findings a	ıvailable
ב	The I	E							autops perform	ed? dea		letion of ca □ No	use or
<u> </u>	ien: intifica	ВеС	25. Was case referred to medical examiner?					26. Place of De	eath (Check only one				
5	hysic lidire	70	1 Yes 2 No	ospital: 1 🗆 Inpat		Outpatien	3□ DOA Othe	4 Nursing	Home 5 ☐ Reside	nce 6 Other ((Specify)		
=	ng P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b ay Yeer)	. Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury occurred			
200	tendi leath. tor: A the fa	catí	2 Accident investigation 3 Suicide 6 Could not be					′es 2 ☐ No	20(1 1: (2)				
	or Al after of Direction by	Certification	4 Homicide determined	building, e	niury - At nome, etc. <i>(Specify)</i>	tarm, stre	et, factory, office		28f. Location (Str City or Town	eet and Number o State)	or Hurai H	oute Numb	er.
-	spital ours nerel filled		29a. Certifier ↑☐ Certifying Phys	ician: To the bes	t of my knowled	ne. death	occurred at the tim	e, date and plac	e and due to the ca	use(s) and manne	ar as state	d	
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	(Check only 2 Medical Examir one)	er: On the basis of and manner s	of examination a tated.	and/or inv	estigation, in my op	inion, death occ	curred at the time, da	te and place, and	due to the	e cause(s)	
i	To t withi To tl	Ž	29b. Signature and title of certifier				29c. License	number	29	d. Date signed (A	Aonth, Day	v, Year)	
			ma					2550	23	1/11/05			
Ól	4-4		30. Name and address of person who co	mpleted cause of	death (Item 23a	Type.	Print) 126 OPa	14.+	lagersto	wn m	021	742	
	Sta Registr		31. Date filed (Month Pay, Year) 2 20	05 32. Bégist	trar's Signature	Sp	whi		25 Lagers to				
						/_							

			For State Registrar	State of M	aryland /		artmen tificate			and M		gien Reg. N	ZUUT	5 0	1808
	° Physici	an	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Da	ay Year		Time of Death
	/Medic		GEORGE WASHINGT								Jan11	200	5	1	2;15A M
	Examin	er	4a. Facility Name (If not institution,						Location of	of Death		40	c. County of De	ath	
			RAVENWOOD LUTHE 5. Social Security Number		je (In yrs. last	hirthday)	HAG]	ERST	OWN If Under	24 Hrs	9 Date of Bir		ASHINGT		/O++
	Funeral Director		212-14-6699	1 M 2 □ F	_82	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da				(State or Foreign
	D		Usual Residence of Decedent								FEB. 22	, L	922 MA	RYLA	ND
	rylan thow		10a. State 10b. County		10c. City, To	own or Lo									nside City Limits
	Ba-f s	cto	MARYLAND WASHI	NGTON			HA	GERS	STOWN					1	Yes 2 No
	vith th	Dire	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What C	Country?	
	sath v	erai	1183 LUTHER DRI	VE 12. Was Decedent	Ever in 11 C	10.1	Man David		21740					S.A.	41-
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28a-f show eumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed Forces?)		rvas Deced f Yes, spec 1 ☐ Yes 2		spanic Oni n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	+	14. Race - Arr Black, Wh Specify:	ite, etc.	
ŏ	2 hou		15. Decedent	s Education	16	Sa. Deced	ient's Usua	I Occupa	ation			16b. l	(ind of Busines	WHIT s/Industry	
215	hin 7. 9. Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	college (1-4or	5+)	(Give life. L	kind of wor DO NOT us	k done d e retired)	luring most)	of worki	ng				
21	ad wit	Соп	8				MAI	NTEN	IANCE]	PUBLIC:	SCHO	OL
pu	be file d oth event	Be	17. Father's Name (First, Middle, L						18. Mothe	r's Name	(First, Middle,	Maide	n Sumame)		
<u>\\ \frac{\z}{a}</u>	should be nd Mental marked o	ပ္	CLYDE E. STOUFF								BETTS				
a	12 sh h and 7 is n		19a. Informant's Name/Relationsh										or Town, State,		
Specify: Specify:											2540				
ō	Pages nent of I int: If Ite		1 ☑ Burial 2 ☐ Cremation		ceme	tery, cren	natory or ot	her place	- 1						
量			' 4 □ Donation 6 □ Other (Sp. 21. Signature of Fund #1 Source		CEDAR	LAWI	N MEM	. PA	RK !O	$\frac{1}{1}$			ERSTOWN		
Ba	permit. Departr Importe any nji		tow M		M. Dear		AST FU			MF.			ational Maryla		e 21 7 13
	T-1		23a. Part1. Enter the disease of shock, or heart failure. List of	complications that caused	the death. D	o not ente	er the mode	of dying	g, such as				Maryla		roximate val Between
الم	Priysician		Immediate Cause (Final disease or condition	3 C	24	r.c.	0.1.00							Onse	et and Death
	/Medical	disease or condition resulting in death) a. 25 OTI Due t. (or as a consequence 1):											1.0	eek	
	Examiner		Sequentially list conditions	b. Parki	25005	Dis	eas	2						ye	0.15
8	sit ad	iner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	≛ue to (or as	a consequenc	e of									
	and I-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):												
.ge 8760,	cate be executed oblysician and the burial-transit	dical E			2 001100440110	.5 517.									
H 9	flicate g phys			0.											
Geor Box 6	leath certifica attending ph for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			±						23d. Date of de	livery	
11.	death	Physician/Me	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pre Other (spe						Month	Day	Year
gton P.O.	that the de led by the a detached t	hys	9 🗆 Unknown	9□ Unknown											
	requires that the death een signed by the atter nould be detached for u		Part II. Other significant condition	1		g in the un	nderlying ca	use give	n in Part I.				use contribute t		
sh		eted	cerebrovascu	THE WISER	36		-				1 1	/es 2	LINO 3 P	robably	4 Unknown
50 MM	lav 2	Completed by									24a. Was autop		24b. Were a prior to death?	utopsy fir completi	ndings available on of cause of
STOUFFER n of Vital F												2 N		s 2 🗆 N	No
Z Z	siciel certii	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 C E B //	Submotion	200	Othe			(Check only o		a 🗆 🗆		
10 0	J Phys er this eral di	Jan.	27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 ER/0	. Time of		Bc. Injury Work	at		ne 5 🗌 Resid		6 □Other (Speny occurred	ecity)	
S	nding P ath. r: After e funera	atio	1 Natural 5 Pending 2 Accident investig		y Year)	Injury	M		? ′es 2.∐1	No					
S	or Attendate death Director:	Certification;	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of Inj	ury · At home, c. (Specify)	farm, stre	et, factory,	office		2	28f. Location (S City or Tow	Street a	nd Number or R	ural Rout	te Number,
Ö	rs after or rel Director	Cer													
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certifici completely illed in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination a	lge, death and/or inv	occurred a restigation,	t the time in my op	e, date and inion, deat	d place, a h occurre	and due to the ded at the time, d	cause(s date an) and manner a d place, and du	s stated. e to the c	ause(s)
	To the within 2 To the complete	≥	29b. Signature and title of certifier	()	Δ.				number		:	29d. Da	te signed (Mon	th, Day,)	(ear)
		-	· cynthea 1	Kuttney. Oc	endo, n	4		D4	745	1	Ü	Tar	nuary 1	1,2	005
05	H-10		30. Name and address of person v Cynthia Kuther	the completed cause of d	leath (Item 23a	(Type, I	dise (Chur	-ch Ro	ond,	Hagers	s to	un, Ma	17/0	end 2
:	Sta Registr	te ar	31. Date filed (Month, Day Yoar)	2005 32. Registr	ar's Signature	A. C.	wall s								
		1		1	-	10/1	- Carried								

			1 - For State Registrar	State of Maryla	nd / Depa		lealth and			0.0 ==	018	09
	- Division		1. Decedent's Name (First, Middle, Last)	1				2. Oate of Death Month			3. Time of	Death
	Physici /Media		Verta M.	Stewart				January	5	2005	8:00	P^{M}
S. S.	Examir		4a. Facility Name (If not institution, give :			4b. City, Town, or		ath	4c. C	ounty of Oeath		
			Rockville Nursin			Rockvi	11e If Under 24 Hi		N	fontgom		
w _{1,1}	Funeral Director		5. Social Security Number 6. Security 118-14-2608	7. Age (In yr.	s. last birthday) 4 Yrs.	Months Days	Hours Mi		Year) 1910	9. Birth Con Nort	place (State or intry) h Carol	Foreign Lina
	yland		10a. State 10b. County	10c. 0	City, Town or Lo	ocation					10d. Inside Cit	y Limits
	a-fel	ctor	Maryland Montgome	ery	Germanto	own					1 X Yes	2 🗌 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	-	n of What Cou	,	
	ath w	ra	17919 Wheatridge			208				ted St		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Department of Health and Merial Hygiene. Department of Health and Merial Hygiene. See 1 show environments of the Merial Health and Health a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	ļ	Was Decedent of Hi If Yes, specify Cuba 1☐ Yes 2∏ No	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		Race - Amer Black, White pecify: B1		
0	2 hor	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		6b. Kind	of Business/fr	ndustry	
2	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired))	orking				
7	ygien ygien her th	Co		2	House	ewife				Home		
and	be fil htal H bd oth	Be	17. Father's Name (First, Middle, Last) Johnnie Hartsfie	.1.3				_{ame (First, Middle, M} eretta Har		umame)		
2	hould d Mer mark maric	2	19a. Informant's Name/Relationship (Ty		10h Mailie	on Address (Street				- 0	2 11	
, Maryland 21215-0036	and 2 s aith an 127 is r or traus	1 3	Ralph Stewart /					Rumal Route Number, ve German				874
ore	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo	sition (Name of matory or other place Le Baptist	g) Ian	Date 2	Oc. Loca	tion - City or T	own, State	
Ĕ	Pag ment tant:		`4 □Donation 5 □ Other (Specify)	GE	Church	Cemetery	20	005 B	unn,	North	Carolin	ıa
Baltimore,	Departiment Departiment Imported on y in	y 1	21. Signature of Funeral Service License	beig	10		Park Di	DeVol Fune r. Gaithe	rsbu		20877	
	Physician		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations what caused the define cause on each line. Pheumon [d	ath. Do not ent	er the mode of dying	g, such as cardi	ac or respiratory arres	st,		Approximate Interval Betw Onset and De	reen
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	ation						
	uted d ansit	Examiner	S quential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	- 1	cardo	dscul	an disea	SE			
760,	te be executed ysician and le burial-transit	cal Exa	resulting in death) Last	Due to (or as a conse		. 0, 0	Vi Oct					
	2 6											
	at the death certificate be ex by the attending physician tached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown	3c. If yes, outcome of preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal déath 3 ☐	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	,	ear
<u>.</u>	that the od by detac		Part II. Other significant conditions con	stributing to death but not re	sulting in the u	nderlying cause give	n in Part I	23e Did toba	ICCO USA	contribute to t	he cause of de	ath?
Records,	The law requires that the te has been signed by th vage 2 should be detache	eted by						1 Yes	/		pably 4 □Ur	
		Completed						24a. Was an autopsy performe 1 \(\sum \text{Yes} \) 2		24b. Were auto prior to co death? 1 ☐ Yes	ppsy findings av impletion of cau	vailable use of
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Otho	Sorre V	eath (Check only one)				
0	Phys this rat dir	To.	1 ☐ Yes 2 No	1 Unpatient 2	ER/Outpatien	-	4 Nursing	Home 5 Residen			(y)	
ion	Attending I death. ctor: After y the funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? (es 2 □ No	28d. Describe how	r injury o	ccurred		
Division	To the Nospital or Attending Physician: within 24 hours alter death, as a feet this certific to the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	eify)			28f. Location (Stre City or Town,	State)			e <i>r</i> ,
	e Hosp	Medical	29a. Certifier Certifying Physical (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	n occurred at the tim vestigation, in my op	e, date and place inion, death occ	ce, and due to the cau curred at the time, date	se(s) an e and pla	d manner as s ace, and due to	tated. the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	msko Me	in ha	29c. License	number D5/9/	G 290	Date s	igned (Month,	Day, Year)	
YI	10		30. Name and address of person who co	mpleted cause of death (Its	m 23a), (Type,	Print)/	100 10	1 . 11	ah.	0, 2	UKS	
ja.			Patricia Tomsko Na 31. Date filed (Month, Day, Year)	y 1119 Rock 32. Agistrar's Sign	ville f	1Ke, G-1	100, Ro	ockville	M	1D 20	852	
	Sta Registr			105 Merce	& A	perter		· ·				

		•	For State Registrar	State of Ma	iryland /		rtment of F tificate of		Mental Hy	ygiene Reg. No		01810		
	Physicia		1. Decedent's Name (First, Middle, Las		ohn Cim	\G			2. Date of D Month Januar	Da	y Year 2005	3. Time of Death 8:34 A ^M		
	/Medic	_	4a. Fecility Name (If not institution, give	ce Littlejo e street and number)	ин эш	IS T	4b. City, Town, o	r Location of Dea			County of Deeth	0:34 A		
	Examin	er	3026 Ramblewood I				Ellicot				Howard			
	Funeral		5, Social Security Number 6. S		(In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs				lace (State or Foreign		
	Director		216 82 7014	□M 2X3F _	76	Yrs.	Months Days	Hours Min	Nov 1	9, Year,	928 Sout	th Carolina		
	pu »		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation				1	Od. Inside City Limits		
	death with the Maryland ms 23a or 28a-f show rmunt be notified at	20										1 ☐ Yes 2 ☐ X No		
	the N	Director	MD Howard 10e. Street and Number		Ellic	ott_	10f. Zip Code			10g. Ci	itizen of What Cour	ntry?		
	aa or	٥	3026 Ramblewood Ro	naď			21042)			ited Stat	•		
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	/as Decedent of H Yes, specify Cuba		Specify Yes or N		14. Race - Americ	an Indian,		
20	within 72 hours after death with the Marylan jiene. rithen "naturel", or ftems 23e or 28e-f show then "naturel", or ftems 23e or 28e-f show the Medical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	1	Yes, specify Cuba	sn, Mexican, Pue Specify:	no Hican, etc.)		Black, White, Specify: Wh:			
212-0030	2 hou	led	15. Decedent's Ed	ducation	168	a. Deced	ent's Usual Occup	ation		16b. F	(ind of Business/In-			
2	within 72 ene. than "nat	Completed	(Specify only highest gra	de completed) College (1-4or 5-	+)	(Give k	rind of work done O NOT use retired	during most of wo d)	orking					
7	tiled wit Hygiene other the	Con	12			Hon	emaker				wn Home			
		Be	17. Father's Name (First, Middle, Last)						me (First, Middi	le, Maidei	n Sumame)			
yian	should be and Mental marked of umatic ev	ဥ	John N. Littlejoh		- 40	4 44 10		Nell We						
ā	0 2 2		19a. Informant's Name/Relationship (1				ural Route Number, City or Town, State, Zip Code) Ellicott City, MD 21042					
a)	ges 1 and it of Heatith If item 27 or other to		Janice L. S. Shell 20a. Method of Disposition	Lton/Daugni	20b. Place		ition (Name of atory or other place		Date		ocation - City or To			
more,	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify						1-2005	E11	icott Cit	-sz MD		
Sait	permit. Page Department Important: If any injury or once.		11. Signature of Funeral Service Licensee 10 M01044 22. Name and Address of FacilitHarry H. Witzke's E									Ly FH Inc.		
	005 e a	7. 7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									MD 21043 Approximate		
	eta a la		shock, or heart failure. List only	one cause on each line	θ		11 1	4.4 1	20		,	Interval Between Onset and Death		
>	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. MCT MST V Nov Smwl) Cell Luwy CurveT2 Due to (or as a consequence of):										4 months		
	Examiner			Due to (or as a	consequence	of):	-					3 months		
		e	Sequentially list conditions, if any, leading to immediate	b. Die to (or as a	consequence	of):	2 15					rnousing		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.											
Ć	an an rial-tr		resulting in death) Last	Due to (or as a	Due to (or as a consequence of):									
09/89	ficate be executed physician and is the burial-transit	edical	•	d										
	ertific ling p	Mec	IF FEMALE:	22- Muss sutsesses										
X Q	at the death certifi by the attending I stached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal deat		Ectopic pregnancy	,			23d. Date of delive Month	ery Day Year		
j	the de	ysic	1 ☐ Yes 2 👺 No 9 ☐ Unknown	4□Pregnant at i 9□ Unknown	time of death	2□	Other (specify) _							
ŗ.	requires that the een signed by the hould be detache		Part II. Other significant conditions of	ontributing to death bu	it not resulting	in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to th	ne cause of death?		
ras,	quires n sigr	ed by							10	Yes 2	No 3□ Prob	ably 4 Unknown		
ဂ္ဂ		oiete							24a. Wa		24b. Were auto	psy findings available		
Vital Record	The le he age	Completed							aut per 1 ☐ Yes	opsy formed? 2 ½ No	death?	mpletion of cause of		
<u> </u>	10	BeC	25. Was case referred to medical					26. Place of De	eath (Check only					
01 <	d is	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/C	utpatient	3□ DOA Oth	er: 4 🗆 Nursing	Home 5 Res	sidence	6 ☐Other (Specify	y)		
	ding Atter	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2 ∐No	28d. Describe	how inju	ry occurred			
DIVISION	Atter actor by the	iffica	3 Suicide 6 Could not be determined	28e. Place of Inju		farm, stre	et, factory, office		28f. Location	(Street a	nd Number or Rura	I Route Number,		
5	oital or urs afte sral Dir illed in			building, etc		·								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical		ysician: To the best o niner: On the basis of and manner stat	examination a									
	To the within 2 To the complet	ž	29b. Signature and title of certifier	e number				Day, Year)						
,			1 11 chulus Kord	well no			173	8509		Ja	nuary 10	, 2005		
00			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas Koutreland 11065 Light Paragent Phy Columbia MD 21044											
	Sta	to	NILTURAS KOUTTE (CAS) 31. Date filed (Month, Day, Year)		1's Signature	TUYE	ict "	Column	JUST IND	, ,	- 1			
	Registr		JAN 1 1	2005	we b	1 4	best							

DHMH 17 Rev 1/2001

thomas, MED FORD

			For State Registrar		State of N	Marylan		artment of H rtificate of I		d Mental Hy	/gien@ Reg. No.	005	01811
	Dhunini		Decedent's Name (First,	Middle, La	ast)					2. Date of D		Vaar	3. Time of Death
	Physici /Medio		Medford		Thoma	15				JANUA		2 2003	5 2242 M
1	Examir	er	4a. Facility Name (If not ins			-		4b. City, Town, or		eath		County of Dea	
				MORI		PITA		EAS				TALE	SOT
	Funeral Director		5. Social Security Number 218–14–4331		Sex 1 → M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D	ay, Year)	9. Bin Co MAI	thplace (State or Foreign buntry) RYLAND
	M ■		Usual Residence of Deced	ent County		10c Cit	y, Town or Lo	ncation					10d Inside Ciby Limite
	Maryli f sho	ō		,	NNE'S								10d. Inside City Limits 1 ☐ Yes 2 X No
	the 1	rect	10e. Street and Number	CEN A	INNE 5	GRA	SONVILI	10f. Zip Code			10a Citiz	en of What Co	
	aa or	Funeral Director	4406 MAIN ST	PREET				21638			USA	en or what co	ountry r
	death	era	11. Marital Status		12. Was Decede	nt Ever in U		Was Decedent of Hi	spanic Origin'	? (Specify Yes or N		4. Race - Ame	nican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination is the motified at once.	by Fur	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 🕱 Div		Armed Force 1 XYes 2 [If Yes, Give Year or Date:	□Nº 194	43-	f Yes, specify Cuba 1 ☐ Yes 2 🎛 No	n, Mexican, Pi Specify:	uerto Rican, etc.)		Black, Whit	
21215-0036	2 hou	pe		cedent's E		s: 194		ient's Usual Occupa	ation		16h Kin	d of Business/	Industry
215	nio 72 na "na	Completed	(Specify only Elementary/Secondary (0	highest gr	ade completed) College (1-4c		(GIVe	kind of work done of DO NOT use retired	furing most of	working	100.14	a or basiness	maastry
21	d with giene er tha	Com	7	7-12)	College (1-40	3+)	BOAT	BUILDER			MAR	INE	
	be filed stal Hygi of other event, I	Be (17. Father's Name (First, M	liddle, Lasi	")				18. Mother's	Name (First, Middle	, Maiden S	Sumame)	
Maryland	2 should be and Mental la marked c	To	GLENN THOMAS	S					MAUDE	BAKER			
Jar	2 shot and lam		19a. Informant's Name/Rei							Rural Route Numb		Town, State, 2	Zip Code)
	t and tealth tm 27		MEDFORD THON	IAS,	JR./SON	00h D			E, GRAS	ONVILLE,		21638	
Baltimore,	Pages nent of thint: If its iry or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem			0	emetery, cren	sition (Name of natory or other place MEMORIAL	9)	Date	20c. Loc	ation - City or	Town, State
턡	it. Partmer intant injury		' 4 ☐ Donation 5 ☐ Ot			PĂF	RK			/11/2005	EAS	TON, MI)
Ba	permit. Page Department Important: II any injury o		Chal	Me	1/2/1		FE	Name and Addres LLOWS, HI OSHAMRO	ELFENBE	IN & NEWN	IAM FI	JNERAL 21619	HOME, P.A.
			23a. Part1. Enter the disea shock, or heart failure	ise, or com	plications hat caus	ed the death	n. Do not ente	er the mode of dying	g, such as card	diac or respiratory a	rrest,	21019	Approximate
	Physician		Immediate Cause (Final disease or condition	. List only	1/								Interval Between Onset and Death
	/Medical		resulting in death)	-		ntri C		lacv	YCar	010			2 Days
	Examiner		Sequentially list conditions	- 1	b. Di	alat	ed	CARO	DIOM.	YOPATH	Y		1 year
	φ ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Į	Due to (or a	as a consequ	ence of):						Jorg
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	U	Onar		Artero)	Disease			20 years
60,	icate be executed physician and s the burial-transit	al E			DBB (Or a	is a consequ	dence or):						9
68760	ificate be executed g physician and as the burial-transit	edical		•	d				-				
_	leath certifi attending I for use as	/Me	IF FEMALE:		23c. If yes, outcom	e of pregna	ncv				0.0	Id Data of dall	
Вох	atter of for u	Physiclan/M	23b. Was decedent pregna in the past 12 months		1 ☐ Live birth 4 ☐ Pregnant	2 ☐Fetal	death 3	Ectopic pregnancy Other (specify)			23	ld. Date of deli Month	very Day Year
P.O.	at the de by the a tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unknown								
	w requires that been signed b should be deta	by P	Part II. Other significant co	nditions o	contributing to death	but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did t	obacco usi	e contribute to	the cause of death?
ğ	equire en sig suld b		Type 2		siabetes	Mel	11. tus			1/2	Yes 2□	No 3 Pro	obably 4 Unknown
Vital Records,	The law requires that the death cert the has been signed by the attending age 2 should be detached for use	Completed	Duslipi de	nia						24a. Was	an	24b. Were au	topsy findings available
ř	The law cate has page 2:	mo:	Hyperte	NSIE						autor perfo 1 Yes	rmed?	death?	ompletion of cause of 2∰No
Ita	ician: Th certificate rector, pag	Be	25. Was ase referred to m examiner?						26. Place of I	Death (Check only o		1 🗆 163	24110
	sic ib i	2	1 ☐ Yes 2 ☑ No		Hospital: 1 X Inpa	tient 2 🗆 l	ER/Outpatient	3 □ DOA Othe	r: 4 🗆 Nursing	Home 5 Resi	dence 6	Other (Spec	ify)
Division of	tal or Attending Pt s after death. al Diractor: After the ed in by the funeral		27. Manner of Death 1. Natural 5 P	ending	28a. Date of In (Month, D		28b. Time of Injury	28c. Injury Work		28d. Describe			
<u>s</u>	tendi leath. tor: A the fu	catl	2 Accident in	ould not b					es 2□No				
\leq	or At	Certification;		etermined	286. Place of I	njury - At ho etc. <i>(Specify</i>	me, farm, stre	et, factory, office		28f. Location (3 City or Tox	Street and . vn, State)	Number or Ru	ral Route Number,
	spital or ours afte naral Dir filled in		392 Cortifier 1900a	etificin e Dh	weisiem. To the boo	A = 6 == - 1 == =				1			
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier 1 Certifier (Check only 2 Me	dical Exar	ysician: To the bes niner: On the basis and manners	of examinat	ion and/or inv	estigation, in my opi	e, date and pla inion, death o	ce, and due to the curred at the time,	cause(s) ai date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of c	ertifier	1			29c. License	number		29d. Date	signed (Month	, Day, Year)
) Janet	2 () Ann	011		D 5	325	3 40	i -	7-05	
	_	+	30. Name and address of pe	erson who	completed cause of	geath (Item	23а) (Туре, Р						
1	04		TIMOTHY	J	SNIEZEK	. M	0	136	Lednun	AVE	Pre	ston,	MD 21655
ľ	Sta		31. Date filed (Month, Day,		0 2005 Regis	tur's Signat	ure #	South					
	Registra	ir	J	HIA T	0 5000	THE PLANE	بالمرار	7					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Oldio or .	mai y mai n	Cert	ificate o	f Death		Reg. No. 2 (005	0181
	Physician	_	1. Decedent's Nam	ne (First, Middle, La	•					2. Dete of Do Month	et⊓ Day	Year	Time of Death
1	/Medica	1	***		Lillia		ozzini	_	4b. City, Town, or	Januar	_		:50 PM
J.	Examine	r '	• ,	If not institution, giv		er)			Burtons			ntoomer	57
	Funeral Director		5. Social Security N 073 18 2	Number 6. S		Age (In yrs. I	est birthdey) Yrs.	If Under 1 Ye Months Day	ar If Under 24 Hrs	8. Date of Bi	rth ey, Yeer)		(State or Foreign
	pu s	- ⊢	Usuel Residence o 10a. Stete	f Decedent 10b. County		10c. City	, Town or Loc	ation				10d. li	nside City Limits
	sth with the Marylan 23s or 28s-f show ust be notthed at		Md	Montgom	erv	1	rtonsvi						□Yes 2 No
	28e	Ω ⊢	10e. Street end Nu		<u> </u>			10f. Zip Code	ө		10g. Citizen of	Whet Country?	
	23a o	<u>.</u>	3415 Gree	encastle	Rd			208	866		Unite	d State	S
Maryland 21215-0020	urs efter der hi', or items Examiner m	Dy ru	11. Maritel Status 1 ☐ Never Merr 3v Widowed	ried 2□ Married 4□Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? No		es Decedent of Yes, specify C	of Hispanic Origin? (suben, Mexican, Puer No Specify:	Specify Yes or N to Rican, etc.)	0- 14. Rac Bla Specif	ce - American Inck, White, etc.	
2-0	n 72 hours natural, natural Ext	Completed	(Spec	15. Decedent's E	ducetion ade completed)		16e. Decede (Give k	nt's Usuel Oci ind of work do	cupation ne during most of wo lired)	rking	16b. Kind of B	usiness/Industr	У
121	within than the May	E	Elementery/Seco	ondery (0-12)	College (1-4	or 5+)		atric 1			Healtl	aaro	
9	Hygie ther ther		17. Father's Neme	(First, Middle, Last	2		Pear	auric .	1.	me (First, Middle	, Maiden Sumen		
lan	\$ 2 5 5 C	5	Alfred C.						Alice H	Bates			
ary	Short and N	-	19a. Informant's N	ame/Relationship (Type, Print)		19b. Mailing	Address (Stre	eet end Number or R	urel Route Numi	per, City or Town,	Stete, Zip Cod	е)
	9 E F E	1	Thomas To	ozzini/So	n				Chapel Ro				
Baltimore,	S U	1	20e. Method of Dis 1 ☐ Burial 2	position Cremation 3	Removal from Sta	00	lace of Dispos emetery, crem	tion (Name of atory or other p	olace)	Date		City or Town,	
ti m	t. Partmenttant:			5 Other (Special	-	Me	tro Cre		t t	L0-2005	Catons		
Bal	permit. Page Department of Important: if I any injury or once.		21. Signature of Fu	uneral Service Lice	MO10	440	22.	Name and Ad	dress of Facility Hai	cry H. W	litzke's	Family	FH Inc.
-		-	Oler	the disease or com	o - UK	sed the death	1		Columbia			-	D 21043 proximate
1	Physician		shock, or hea	art failure. List only	one cause on	h line.	/ <	and mode or c	dying, such es cardia	o or rospiratory	arroot,	Inte	rval Between set and Death
7	/Medical		Immediate Ceuse disease or condition		De	mei	atic					in	110.05
	Examiner		resulting in death)) ii	e. DC	Due to (or	r es a consequ	ence of):				110	YEM 5
	D = 5	Examine			b							1	
	ufficate be executed g physicien end es the buriel-transit	Xan	Sequentially list co	onditions, mmediate		Due to (or	r es a consequ	ence of):				}	
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	g phy es the	Medical	resulting in death)	Last		Oue to (or	as e consequ	erice ory.					
Вох					d							1	
о. Ш	the ett	riiysicidil	Part II. Other signif	ficant conditions of	ontributing to deat	h but not resu	ilting in the un	lerlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
P.O.	as that the deeth ce igned by the ettendi be detached for use									1	Yes 2□ No	3 Probably	4 Unknown
Division of Vital Records,	lew requires that the las been signed by the 2 should be detache	Completed by								24a. Wei	s en autopsy ormed?	availab	utopsy findings le prior to tion of cause 1?
æ	0 - 0 1	5								10	Yas 2X No	1 ☐ Ye:	s 2 No
/ita	ysician: The is certificate director, pag		25. Was case references	rred to medical						ath (Check only	one)		
£	h sign		1 ☐ Yes 2 ☐	-	Hospital: 1 ☐ Inp		ER/Outpatient	3LI DOA		-	idence 6 Oth		
בט	tending P	5 2	27. Menner of Deal 1 XNatural	tn 5 ☐ Pending investigatio		Dey Year)	28b. Time of Injury		njury at Work? □ Yes 2 □ No	28d. Describe	how injury occur	rea	
Division	or At	e I III Ca	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place of	Injury - At ho , etc. (Specify	me, farm, stre				(Street and Numl wn, State)	ber or Rural Ro	ite Number,
	he Hospi in 24 hou he Funer pletaly fill	egica	29a. Certifier (Check only one)			s of examinat			e time, date and plec y opinion, deeth occ				
	To the Tour		29b. Signature end	title of certifier	1 0			29c. Lice	ense number		29d. Date signe		
	_	-	- au	NUVY			000\7	V 2	1727		January		105
3)0	1	1	_	ress of person who	. / (201 (Item	avre	Park	an Ste	1 Lau	rel M	.D	

31. Dete filed (Month, Dey, Year)

JAN 1 1 2005

State Registrar

Physici /Medic		1 - For Unpend Item 23a, 27, 28a i per me 1840 2 1 - 05 tas Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Death	- 1 0 1 0						
		TIMOTHY R. VINSON	JANUSRY	11, 2005 4:18P. M						
Examin	ier	4a. Facility Name (If not institution, give street and number) 18211 SMOKE HOUSE COURT 4b. City, Town, or Location of Death GERMANTOWN	h	4c. County of Death MONTGOMERY						
Funeral Director		5. Social Security Number 215-74-3271 6. Sex 1 Months 1 Months 1 Months 2 M		year) 9. Birthplace (State or Foreign Country) 1963 Maryland						
faryland show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
ith the Ma or 28a-f	Director	MD Montgomery Germantown 10e. Street and Number 10f. Zip Code	100	N∑Yes 2 □ No g. Citizen of What Country?						
ath with 23a or	ral Di	18211 Smoke House Court 20874		U.S.A.						
filed within 72 hours atter death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f show int, the Macified Examination at the motified at	by Funeral	11. Marital Status 1	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black						
within 72 hours affine. ine	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired)	rking	Bb. Kind of Business/Industry Middlebrook						
buld be filed with Mental Hygiene. arked other ther atic event, I've M	Be		ne (First, Middle, Ma							
s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23a or 28a-f shou other traumatic event, the Modical Examination at the notified at	Roscoe Cooper 19a. Informant's Name/Relationship (Type, Print) Glenda Vinson (sister) 18255 Smoke House Ct., Germantown 20a. Method of Disposition 1888 Name of Disposition 1888 Name of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)									
Elementary/Secondary (0-12) The secondary (1-4or 5+) The secondary (1-4o										
/Medical Examiner he paragraph of the pa	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cocaine Intoxication Due to (or as a consequence of): Due to (or as a consequence of): c. Due to (or as a consequence of):								
fice g ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year						
quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \)						
	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No						
icien: Th certificate rector, paç	ation: To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H 27. Manner of Death 1 Natural 5 Pending investigation investigation investigation	th (Check only one) ome 5 Residence 28d. Describe how							
ending Ph sath. or: After th	75	3 Suicide 6 X Could not be determined 4 Homicide 6 X Could not be building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Bural Boute Number State) 18211 Smoke House						
ending Ph sath. or: After th	Certification:	Found At Residence		n, Maryland						
ending Ph sath. or: After th	dical Certifica		and due to the caus	se(s) and manner as stated						
or Attending Ph after death. Director: After th in by the funeral	Medical Certifica	Found At Residence 29a. Certifier (Check only) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 21 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place are considered as the constant of the constant	, and due to the caus rred at the time, date	se(s) and manner as stated						
ending Ph sath. or: After th	edical	Found At Residence 29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, which is the property of the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of certifier 29c. License number	, and due to the caus rred at the time, date 29d. JAN	se(s) and manner as stated. The and place, and due to the cause(s) The analysis of the cause (s)						

			1 - For State Registrar	State of Mary		artment of rtificate of		R	eg. No.	01814
	Physici	an	Decedent's Name (First, Middle, L.	ast)				Date of Dear Month	Day Year	3. Time of Death
	/Medi		Jane A.		alsh			January		4:15 P M
7	Examir	ier	4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Death		4c. County of Dea	th
			Cherry Lane Nur 5. Social Security Number 6.		res land bloth day	Laure		0.0	Prince G	
	Funeral Director			Sex 7. Age (In	yrs. last birthday,	Months Days		8. Date of Birth (Month, Day, Jan. 14	Year) Co	thplace (State or Foreign buntry) Jersey
	rland		10a. State 10b. County	100	. City, Town or L	ocation				10d. Inside City Limits
	Man	ţō	Maryland Prince	George's	Laur	el				1 ☐ Yes 21 No
	h the	Directo	10e. Street and Number		·	10f. Zip Code		1	0g. Citizen of What Co	untry?
	th wit		11805 Basswood	Drive		20708			USA	
	dea	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
9	or It		1 XNever Married 2 Married	1 ☐ Yes 2 ☐ XNo If Yes, Give		1 Yes 2 No		rican, etc.)	Black, Whit	•
8	hours after death with the Maryland lural', or Itams 23s or 28s-f show al Examinar must be notified at	d by	3 □Widowed 4 □Divorced	Year or Dates:			opecny.		Specify:	
<u> </u>	neti	lete	15. Decedent's E (Specify only highest gr		16a. Dece (Give	dent's Usual Occu kind of work done	upation e during most of worki ed)	ng	16b. Kind of Business	Industry
12	withir ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ractical			Health	
d 2	filled Hygie ther	e Co	17. Father's Name (First, Middle, Las	")		racticar	18. Mother's Name			
an	d be antal ced o	m	John Edmond Wal						valuen oumame)	
<u></u>	should Me mark matter	ဥ	19a. Informant's Name/Relationship		19h Maili	na Address (Stree	Anna Do		City or Town, State, 2	Zin Cordo)
Maryland 21215-0036	nd 2 stith ar	3	Allen Whitehead/						New York, 1	
ē,	Hea Hea tem othe		20a. Method of Disposition	20	b. Place of Dispo	osition (Name of		ate	20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Itams 23s or 28s -1 show my injury or other traumatic event, the Medical Examinating the notified at once.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro	Removal from State	ate of	matory`or other pla Heaven		ary /,		
₹	nit. Fartme		21. Signature of Funeral Service Lice	7	Cemete	-				ing, Maryland
B	permi Depa Impo eny le		1 11/1/2	13.1	50	rancis J. O Universi	ess of Facility Collins Fune tv Blvd. W.	ral Home : Silver Som	Inc ring,MD 20901	
			23a. Part1. Enter the disease, or con	plications that caused the o				_	•	Approximate
	Physician		Immediate Cause (Final	one cause on each line. Cerebral						Interval Between Onset and Death
	/Medical	î I	disease or condition resulting in death)	aDue to (or as a con		0919				Minutes
	Examiner				304001100 017.					
	-	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):					
	certificate be executed ding physician and use as the burial-transit	Examiner	cause. Enter Underlying Cause (Uneaus or injury) that initiated events	C						
ó	an ar rial-tı		resulting in death) Last	Due to (or as a con	sequence of):					
8760,	cate be ohysicia the bu	Physician/Medicai		_ d						
9	ng ph as th	Med	IE FEMALE.							
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnanc	~		23d. Date of deli	very
	D 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐Unknown		Other (specify)	-y		Month	Day Year
P.0	that the de led by the a detached i	h.	9 🗆 Unknown							
Ś	es De	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.		acco use contribute to	
ord	w requir been si should I	ted			· · · · · · · · · · · · · · · · · · ·			1 🗆 Ye	s 2□No 3□Pro	bably 4 🖽 Unknown
ec	¥ CS CS	Completed						24a. Was ar autopsy		topsy findings available ompletion of cause of
<u>~</u>		Con						perform	ned? death?	
Vital Record	nysicien: Th nis certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death			
of \	X sip	2	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3□ DOA Ot	her: 41 Nursing Hon	ne 5 🗆 Resider	nce 6 Other (Spec	ity)
n	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	f 28c. Inju Wo	ry at 2 ork?	8d. Describe ho	w injury occurred	
Sio	Attending r death. ector: After by the funer	cati	2 ☐ Accident investigatio			M 1	Yes 2 □ No			
Division		Certification	3 ☐ Suicide 6 ☐ Could not be determined			reet, factory, office	2	8f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	ospitel or hours afte unerel Dii ly filled in									
	Hos Fur Tely	edicai	(Check only 2 Medical Exal	nysician: To the best of my niner: On the basis of exam	knowledge, death iination and/or in	h occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hospitel within 24 hours a To tha Funerel I completely filled	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen			d. Date signed (Month	
	F X F S			1 /1		D.	L3916	29	January	_ '
7	5		ww	MINO	wen	0			canacity	-, 2005
			30. Name and address of person who William A. Warre			,	S+200+ 1	` D.1.74 D T	MD 00707	
	Ch		31. Date filed (Month, Day, Year)	32. Pegistrar's Si		george's	Street, I	Jaurel,	MD 20/07	
\$ 0.5	Sta Registr		TAN 072		H De	arec.				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY **Physician** WILLIAM WILBURN CLARK 2005 10:25AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs. Director 218-12-5568 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show traumatic event, the Mudical Examinar must be notified at 1 X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 U.S.A. 200 East 16th Street 21701 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII items Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Maryland Motor Vehicle Elementary/Secondary (0-12) College (1-4or 5+) Director Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jason Wilburn Annie Durst ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 4819 Lynn Burke Road, Wayne McKenzie - Nephew Monrovia, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of h Important: If ite any injury or of 1

Burial 2 □ Cremation 3 □ Removal from State Crestlawn Mem. Garden's Jan 14, 2004 Marriottsville, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jure of Fun ral Service Licenses 22. Name and Address of Facility Olin L. MolesworthP.A., Funeral Home overt 20872 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Chronic Kena on Iwake /Medical Due to (or as a consequence of): Examiner pernaterenue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hermhe 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 A No 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 \ No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 A Inpatient Certification: To 2 ER/Outpatient 3 DOA this d 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined n 24 hours after de ne Funeral Directo oletely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1/1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D4309 1-10-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 House Ane Bredenich SAEED 701C CAUD 32. gistrar's Signature Registrar

			1- For Amend Item 29d State of Magdand Ope	partificate of Death	•	e 2005	01816							
	Physici	an.	1. Decedent's Name (First, Middle, Last)		ate of Death	av Year	3. Time of Death							
	/Medi		RUTH REBECCA WEEL		Ionth 3		1							
0	Examir	ner	4a. Facility Name (If not institution, give street and number) KLINE / HOSPICE	4b. City, Town, or Location of Death	1	c. County of Death								
6ie	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min.	ate of Birth Month, Day, Yea T. 15, 19	9. Birth	place (State or Foreign ntry) MD.							
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits							
	he Maryl 8a-f eho	Director	Md. Frederick FREDE	RICK			1 Yes 2 No							
	th with t	ai Dir	10e. Street and Number 149 Fairfield Drive	10f. Zip Code Z/70Z	-	itizen of What Cou	ntry?							
980	72 hours after death with the Maryland natural', or items 23s or 28s-1 show deat Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican Yes 2 No Specify: 	es or No- , etc.)	14. Race - Ameri Black, White, Specify: BL	etc.							
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Maryland 2	thould be filed and Mental Hygin marked other matic event, II	To Be Co	17. Father's Name (First, Middle, Last) CARL BROOKS	18. Mother's Name (Firs. HELEN L	t, Middle, Maide									
	12 sho h and 7 le m traum		19a. Informant's Name/Relationship (Type, Print) (SON) 19b. M JOSEPH A. WEEDON SR, 149	ailing Address (Street and Number or Rural Roun Fairfield Dr. FPEDER										
Baltimore,	Pages 1 and ment of Healt ant: If Item 2' ary or other		20a. Method of Disposition 20b. Place of Disposition 3 Removal from State 4 Donation 5 Other (Specify)	sposition (Name of Date crematory or other place) VEN MEM, GAR, JAN, 7, 2		ocation - City or To	own, State							
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility. FUNERAL Home GARY L. POSITIVE FUNERAL HOME 10 WEST SOUTH ST FREDERICK, MD. 21701											
	Physician	y, y,	23a. Pert1. Enter the disease, of complications that caused the death. Do not shock, or near failure. List only one cause on each line.				Approximate Interval Between Onset and Death							
	/Medical Examiner		Due to (or as a consequence of):											
	uted d	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classe of Figure 1) that initiated events c.											
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on of Vital	Phys this al dii	tlon: To	1 Yes 2 No 1 Inpatient 2 FR/Outpa 27. Manner of Death Natural 5 Pending 2 Accident investigation 1 Inpatient 2 FR/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim.	e of 28c. Injury at 28d. D	Residence Pescribe how in	6 Other (Specifically occurred	House thense							
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		ocation (Street a ity or Town, Stat	nd Number or Rura e)	al Route Number,							
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do not be the property of the pasts of examination and/or and manner skate).	eath occurred at the time, date and place, and durinvestigation, in my opinion, death occurred at t	e to the cause(s	s) and manner as s od place, and due to	tated. o the cause(s)							
)	To the comp	W	29b. Signature and title of certifier	η) ^{29c. License number} D 1 G H 2 8	29d. Da	ate signed (Month,	Day, Year) 01/07/05							
	4		30. Name and address of person who completed cause of death (Item 23a) (Ty) CASPER CUNE 300 WEST 97		10 21	101								
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 1 2005 32. Registrar's Signature	Acres :										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie [26] 15 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) 3. Time of Death Year Month **Physician** Invary 1452 ARNOLL 25 MARVIN 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore CUTER Randallstown Nathwest HOBDITEV If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min.

Dec. 18, 1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**X M 2□ F 62 Maryland Director 216-44-2234 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rel', or Items 23a or 28a-f show Ever-ther must be notified at Owings Mills 1 ☐ Yes X2X No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 U.S.A. 139 Wilgate Rd. Funerai Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Maryland 21215-0036 1 Yes XX No Specify: Specify: þ 3 Widowed 4 Divorced White "neturel", Completed the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) other then permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then eny injury or other treumatic event. If Item Lithographic Operator Administration 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie Elnora Nine Wesley Taylor Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Owings Mills, MD 21117 139 Wilgate Rd. Patricia Arnold/Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition XXBurial 2 Cremation 3 Removal from State Evergreen Mem.Gardens 1/28/05 Finksburg, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Juperal Septice Licensee once. 11605 Reisterstown Rd. Owings MI11s, MD21117 rohow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vascular Docase Pnysician Coronary disease or condition resulting in death) Attenositeratio /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consumence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month ō Day Year in the past 12 months? 4□ Pregnant at time of death 5 Other (specify) 2 No ed by the a P.O. 9 Unknown 9 I Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Sundrome 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen Hypertensión 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☑ No Mellita certificate 1 TYas Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 KEP/Outpatient 3 □ DOA 2 1 ☐ Yes 25 No this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ō 24 hours a To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number DO055441 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) andalleto

State Registrar

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3	רחופום	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hisp if Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto i	cify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.	
	y V	1 ☐ Never Married 2 ☐ Married 3X☐ Widowed 4 ☐ Divorced	tXXYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes ŽŽNo	Specify:		Specify:	White	
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F	2	Turner Francis 19a. Informant's Name/Relationship		19b. Mai	ling Address (Street an		ce Herd		ate. Zip Code)	
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		20a. Method of Disposition	20b. I	Place of Disp	osition (Name of ematory or other place)	D	ate	20c. Location - Cit	ty or Town, State	
		1 A Burial 2 □ Cremation 3 [Themoval indin State	_	Cemetery	1/28/	2005	Scaggsvi	lle, MD	
XIIX		21. Signature of Funeral Service Lice	ensee	2	22. Name and Address	of Facility D	onaldso	n Funera	1 Home, P .	Α.
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		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each line.				r respiratory arr	est,	Approximate Interval Betwo Onset and De	een eath
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		resulting in death) Last	Due to (or as a consec	quence of):						
	20103		d							
	VIME.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of	of delivery	
-	200	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		□Ectopic pregnancy □ Other (specify)			Month		ear
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3	2	Part II. Other significant conditions	contributing to death but not re-	sulting in the	underlying cause given	in Part I.			ute to the cause of de	
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							1 Yes	2□No 1	Yes 2□No	
10	o De	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:	XER/Out-att	ent 3 DOA Other	26. Place of Death			(Specific)	
P	-	27. Manner of Death	28a Date of Injury	28b. Time	SIL SELBON	4 🗆 Horsing Hor		ence 6 Other ow injury occurred	(эрөспу)	
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	Se		found at ho	me			Laurel,	Maryland	1.) i
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	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (#		
1117			11 2.0		0 C I	M E		JANUARY 2	25, 2005	
II.		1 / 1	M. Kingan	4						
		30. Name and address of person who	completed cause of ath (Ite	m 23a) (Type					RYLAND, 21:	

DHMH 17 Rev 1/2001

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			1 - For State Registrar	Otate of Marylar		ate of Dea			g. No 2 0 0 5	01010
			Decedent's Name (First, Middle,	, Last)		ato 01 D01		2. Date of Death		3. Time of Death
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	/Medio Examin		4a. Facility Name (If not institution,			ity, Town, or Loca	ation of Death	- (4c. County of Dea	ith
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	Funeral			6. Sex 7. Age (In yrs.	11	ider 1 Year If U	Jnder 24 Hrs. ours Min.	8. Date of Birth	(9. Bi	rthplace (State or Foreign ountry)
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	pu *		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Location)			10d Janida City Limita
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	28a-f	ect	10e. Street and Number	marciel	Jeury	Zip Code		10	g. Citizen of What C	•
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	hours after death with the Maryland turel', or Items 23e or 28a-f show at Examiner must be natified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was De	ecedent of Hispan	nic Origin? (Spe	cify Yes or No-	14. Race - Am	
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\mathbf{z}	rit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar naturent of Health and Mental Hygiene. cortant: If Item 27 is marked other then "neturel", or Items 23e or 28a-f show injury or other treumatic event, Ite Medical Examiner must be notified at a.		1 £	sen/Wife		inset	Drive	= Sev	erna Po	urk, MD
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B	death a attel	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		c pregnancy (specify)			Month	Day Year
P.O.	res that the de signed by the a i be detached f	Physician/Med	9 Unknown	9□ Unknown						
	s tha	by P	Part II. Other significant condition	ns contributing to death but not res	ulting in the underlyin	g cause given in	Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Records,	w require been sig should b	ed	Hy Sertert	W-				1 ☐ Yes	s 2.0 1 (No 3	robably 4 Unknown
၁၁	aw as b	Completed	Hyps tryr	sivism				24a. Was an	24b. Were a	utopsy findings available completion of cause of
	The I	mo:						perform	ed? death?	
/ita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?				Place of Death	(Check only one)	
of V	hysio this o	ပ္	1 ☐ Yes 2 No						ice 6 □Other (Spe	ocify)
n o	ding Phys h. After this funeral dir	on:	27. Manner of Death 1 XNatural 5 ☐ Pending		28b. Time of Injury	28c. Injury at Work?		8d. Describe hov	v injury occurred	
Sic	Attending r death. sctor: After by the funer	cat	2 Accident investiga 3 Suicide 6 Could no	ot be	M	1 🗆 Yes		06 1	and Months and O	
Division of Vital	or A after Direction by	Certification:	4 ☐ Homicide determin	28e. Place of Injury - At he building, etc. (Specif	отте, татті, street, тас У)	tory, onice	2	City or Town,	eet and Number or R State)	urai Houte Number,
_	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best of my kno	owledge, death occur	ed at the time de	ite and place a	nd due to the car	use(s) and manner a	s stated
	24 h e Fur letely	Medical	(Check only 2 Medical E							
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License num	nber	/ 29	d. Date signed (Mon.	h, Day, Year)
			15.ms	mm	1 - 1	Das	5 025	4	1-2	4-05
	antl		30. Name and address of person w	who completed cause of death (Item	n 23a) (Type, Print)	0 1	-	-	- 01 /	
	Ju		Bahador	who completed cause of death (Iter	1400	J. Clar	~ He	or be	31Md 2100	01
	Sta		31. Date filed (Month, Day, Year)	Registrar's Signa	ature					
	Registr	ar	JAN 2 6 21	UUD LEEDEN D	Modera	7				

		l.	For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H		nd M	-	ne 0 0	5	018	20
	Physic:		1. Decedent's Name (First, Middle	e, Last)					2. Date of Death		Vone	3. Time o	f Death
	Physici /Medic		GILDA		A	BRAHAMS			JANUARY_	24, 20	05	7:11	_A_ ^M _
	Examin	er	4a. Facility Name (If not institution			4b. City, Town, or				4c. County	of Death		
			111 HAMLET HI 5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	BALT If Under 24		E 8. Date of Birth		O Bidb	N/A	
	Funeral Director		220-05-8914	1 M 2 F	89 Yrs.	Months Days	Hours	Min.	JAN.9,19	16	Coul	place (State ontry)	n Foreign 1D
	100		Usual Residence of Decedent			1			07111.5,15	10			
	show	5	10a. State 10b. County	N / 5	10c. City, Town or Lo	ocation			_		1	10d. Inside C	ity Limits 2 🗌 No
	the M	Director	MD 10e. Street and Number	N/A		10f Zin Codo	BALT	IMOR		Citizen of M	/hat Carr	^	2 140
	aa or	흐	111 HAMLET HI	II DOAD #51	9	10f. Zip Code	21210	Λ	Tog	. Citizen of W	nat Coul	USA	
	ms 2	Funeral	11. Marital Status	12. Was Deceden		Was Decedent of Hi If Yes, specify Cuba			cify Yes or No-			can Indian,	
98	after or ite		1 Never Married 2 Marr	Armed Forces 1 ☐ Yes 2 [7] If Yes, Give	No	1 Tes, specify Cuba 1 ☐ Yes 2 [V] No	n, mexican, Specify:	Pueno F	tican, etc.)		k, White,		_
8	72 hours after death with the Maryland naturel; or items 23a or 28e-f show dical Examiner must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:		^				Specify.		WHITE	<u> </u>
15	in 72	olete	15. Deceden (Specify only highes	t's Education st grade completed)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation <i>luring most c</i>	of workin	16	b. Kind of Bu	siness/în	dustry	
212	d within 7 plene. r than "n Ir e Med	Completed	Elementary/Secondary (0-12)	4 College (1-4or	5+)	MAKER	,			OWN HO	ME		
aryland 21215-0036	e filec al Hyg I othe vent,	BeC	17. Father's Name (First, Middle,	Last)			18. Mother	's Name	(First, Middle, Ma				
<u>yla</u>	2 shouid be and Mental is markad raumatic ev	To	MILTON		LEVI	N	RACI	HEL				HERM/	\N
Mar	12 short and rism		19a. Informant's Name/Relations			ng Address (Street a							
	s 1 and 2 should be filed if Health and Mental Hyg itam 27 is markad othe othar traumatic event,		EMILY ABRAHAM 20a. Method of Disposition	S / DAUGHTE	20b. Place of Dispo	RIVERSIDE	DRIVE			- NEW			.0025
Baltimore,	2°= 5		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, crei	matory or other place AEL CEMET	· 1						
äţį	in in its		21. Signature of Funeral Service			2. Name and Addres			L LEVINS			E, MD	
ñ	Dep impo any		> Educard	Rund		8900 REIS		00					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	d the death. Do not ent						,	Approximat	9
ĮI.	Pnysician	0 1	Immediate Cause (Final disease or condition	Liv	er failure							Onset and	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							1 hex	<u>~~</u>
		16	Sequentially list conditions,	b. Due to (or	a consequence of	heart dis	sease					ZOU	5
	uted J ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bus	pardancin								
o,	sicien and burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequence of):						-		
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9	Jeath certificate attending phys I for use as the	a ·	IF FEMALE:	020 Kura autom		-							
Вох	death c	Iclan/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date Mon			Year
o.	0 0 0	Physic	1	9□ Unknown	it time of death 3E								
S, P	es that the igned by th be detache	by Pł	Part II. Other significant condition		but not resulting in the u	nderlying cause give	n in Part I.		23e. Did tobac	co use contri	bute to th	ne cause of c	leath?
ords	w requires been sign should be		Aarte	arevrys m	1				1 ☐ Yes	2 11 46	3 🗌 Prob	ably 4 🔲	Jnknown
Vital Record	aw Is b	ompleted		3					24a. Was an autopsy	24b. W	ere auto	psy findings mpletion of c	available
<u>س</u>	Th ate pag	Con							performe	d? de	eath?	2 No	2000
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe			Check on one				-
ot	Phys this ral dii	: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpati	ent 2 ER/Outpatier		4 LI INUIS		e 5 Residence			y)	
on	Attending in death. actor: After by the funer	tlon	1 Natural 5 Pendin 2 Accident investig	g (Month, Da	Year) Injury	Work	? ′es 2.⊟No		od. Doscribo now	inquity occurre	u		
Division	or Attendated after death Diractor:	ertification;	3 Suicide 6 Could determ	ined 286. Place of In	jury - At home, farm, str	eet, factory, office		28	8f. Location (Stree	at and Numbe	r or Rura	I Route Num	ber,
	spital or Al	Cert	Tomodo	, building, e	tc. (Specify)				City or Town, S	state)			
	8 - 7 -	edical	(Check only 2 Medical	g Physician: To the best Examiner: On the basis	of examination and/or in	h occurred at the tim vestigation, in my op	e, date and inion, death	place, ar	nd due to the caus	e(s) and man	ner as st	tated)
	To the Hos within 24 hr To the Fun completely	Med	29b. Signature apolititle of certifie	and manner s	tated.	29c. License				Date signed			
	F3F8)	* hud	MAKE	\geq	2	14 70	10					-
1/	TA		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print)	17 2	10	4D 21	· Jun	~~	1-0	
[1	J'		10755	Fallskow	Sale Zon	Luther	will	- V	MD 21	093	.		
	Sta		31. Date filed (Month, Day, Year) JAN 2	6 2005 St. Regist	rar's Signature	Societies							
	Registr	ar	JANA	0 2003	SCHOOL NO. P.								

State of Maryland / Department of Health and Mental Hygien 0 5 1- Stote Registre-AMEND ITEM #8 PER FH G839 1/26/05caste of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 2005 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of De Examiner α 10 O Date of BirtMAY 19, 1975 plece (State or Foreign If Under 1 Year Social Security Number Sex yrs. last birthday) **Funeral** Days Months Hours 1 M 2 V Director Yrs Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, 10d. Inside City Limits 28a-f show item 27 is marked other then "naturel", or items 23s or 28s-f shov other traumstic event. The Medical Examinar must be modified at 1 THYES 2 □ No Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 36 Funeral Was Decedent Ever Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "naturel", or iter any injury or other traumatic event. It a Medical Examination. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lompliance 011 Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) anc GREEN 9a) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State PARK andal Istown * 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature Juneral Service License 22-Name and Address of Facility 270 Figher the disease, or complications that caused the death. Do not enter the mode of oring, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Acute (eukemin **Physician** Yeurs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duality (or as a consequence of) Examiner signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 Yes 2 No filled in by the 2 Accident within 24 hours after deatl

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00043748 2005 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) BALT MORE POULLAS MD 5M (17-1 SMEET ORICALI MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 6 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	State of Maryla		artment of F			giene	005	018	322		
Physici	20	Decedent's Name (First, Middle, Last) 2. D							Year	3. Time of D	Death		
/Medic		Claude Lav	vere Bartles				January	Day 21	2005	9:16	PM		
Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death					ith		ounty of Death				
		Laurel Regional 5. Social Security Number 6. S		last hirthday	Laurel If Under 1 Year	If Under 24 Hr	S O Bata of Bird	_	nce Geo				
Funeral Director		333-16-5099 Usual Residence of Decedent	Months Days Hours Min. (Month, Day Jan. 21										
yland sow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City	Limits		
Mar.	ţċ	MD Prince Ge	eorge's La	urel						1 🗌 Yes	2 √ No		
th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizei	n of What Cour	try?			
th wi	Funeral Director	9000 Eastbourne	Drive		20	708			USA				
r dea	inei	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14.	Race - Americ Black, White,				
ING Z IZ 13-UU30 be filed within 72 hours after death with the Maryland hal Hyglene. id other than "natural", or items 23a or 28a-f show event, it a Madical Expandent coast be nutified at	þ	1 Never Married 2 Narried 3 Widowed 4 Divorced	4 730 Chip	7 4 2	1□Yes 2√XNo	Specity:	,		pecify: Whi				
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ABLYIBING 2 should be fit and Mental H is markad of raumatic ever	P	Claude L. Bart 19a. Informant's Name/Relationship (7)		19h Mailir	ng Address (Street		ie Clary	City or T	our State Zin	Codol			
re, Maryla s 1 and 2 should if Health and Men item 27 is marka other traumatic		Elaine A. Bartles			Eastbour				20708	C009)			
ore, IVI		20a. Method of Disposition			sition (Name of natory or other place		Date	•	ion - City or To	wn, State			
DAILLIMORE permit. Pages 1 Department of H Important: If ite any injury or ot		1 🔀 Burial 2 □ Cremation 3 □ * 4 □ Donation 5 □ Other (Specify	Mailioval Itolii State		n Nationa		17/2005	Arlin	gton, V	ZΑ			
altimore, mit. Pages 1 a partment of Hea portant: If item y injury or othe		21. Signature of Funeral Service Licen			. Name and Addres								
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Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrythmia a. Cardiac Arrythmia											
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c oc artifica ing ph		IF FEMALE:											
COIdS, P.O. BOX 68/ wrequires that the death certificate been signed by the attending phys should be detached for use as the	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d	. Date of delive Month	ry Day Ye	ar		
THECOIDS, P.O. The law requires that the late been signed by the bage 2 should be detached.	by							Did tobacco use contribute to the cause of death? ☐ Yes 2★No 3 ☐ Probably 4 ☐ Unknown					
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UNISION OF VITAI HER TO THE HER TO THE INC. To the Hospital or Attending Physiclan: The law within 24 burus after death. To the Funeral Director: After this certificate has complately filled in by the funeral director, page 2	edical	29a. Certifier 1 IX Certifying Ph (Check only one) 1 IX Certifying Ph 2 ☐ Medicel Exem	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time of the time of the control of	ne, date and place pinion, death occ	e, and due to the curred at the time, c	ause(s) and late and pla	d manner as sta ce, and due to	ated. the cause(s)			
To 1 To 1	Σ	29b. Signature and title of certifier A	MD At	ren Di	9 29c. License D42				gned (Month, E ry 22,				
1441		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)								
101 '		P.S. Aujla, MI			oad, #13	Blader	sburg, M	D 2	0710				
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign		hails?								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Joseph Brooks January 24, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore paryland General YOSPITOL CI If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 8. Date of Birth Month Day, April II, last birthday 9. Birthplace (State or Foreign **Funeral** Min. Days 218-36-0433 1 □X M 2 □ F 65 Hours Mary Tand Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Iteme 23a or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland NΛ Baltimore 1**∏**Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5302 Greenhill Avenue 21206 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 No If Yes, Give Vietnam Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 No Specify ģ Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, the Me any pings. Elementary/Secondary (0-12) College (1-4or 5+) Autoworker General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William T. Brooks Barbara Josephine Chetelat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas M. Brooks/Brother 5302 Greenhill Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Most Holy Redeemer 1/28/05 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Facility 5305 Harford Road hustina Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and is the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 4No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Olre 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who

31. Date filed (Month, Day, Year)

1/0

2005

Mari

land Greneral

completed cause of death (Item 23a) (Type, Print)

32. Regiar's Signature

Mil

				State of Maryland / Department of Health and N State Registrer State of Maryland / Department of Health and N Certificate of Death	Mental Hygiei	2005 01001				
		Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) WENDY BORTNER	JAN 2	Day Year 3. Time of Death 2005 // 45 A M				
		Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UPPER Chesa Reto Ke Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death HARFORD, 9. Birthplace (State or Foreign Country)				
		Director		218-50-5306	MArch 3,	1961 MJ)				
		ath with the Marylan 13e or 28e-f show ust be myllited at	Director	M.D. HARFORD ABING-DON 10e. Street and Number 10f. Zip Code		1 ☐ Yes 2 No Citizen of What Country?				
	9	filed within 72 hours after death with the Maryland Hygiene. other than "neturel", or flems 23e or 28e-f show ent, II.e Modeal Examitrational benomined at	Funeral	2 MAPIE LUTEATH CT 2 DO 9 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban, Puerto 1	·	14. Race - American Indian, Black, White, etc.				
15	15-0036	in 72 hours a "netural", o	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use retired)	king 16b	Specify: White D. Kind of Business/Industry				
1	nd 212	should be filed within and Mental Hygiene. Is marked other than aumatic event, ILE M	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Maid					
	Maryland		To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur						
105		is 1 and 2 soft Health artitlem 27 ts		DeBORAH NESS 1401 Thomas RUN 20a. Method of Disposition 20b. Place of Disposition (Name of	RD, Bel	AIR MD 21015				
122	altimore,	Pages nent of ant: ff i		1□strial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) PARKWOOD CEMETERY	105 T	Botto. No.				
-	Bal	permit. Pag Department Importent: f any injury o once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARTIEN MILLER 75 27 6 9 FORD R	STELLA FUR Bolto	Mo. 21234				
•	ł	Fnysician /Medical Examiner		23a. Rart/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a						
76131	8760,		ledical Examiner	Sequentially list conditions, It as y, leading to him ediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last b. Citia to (or as a consequence of) c. Due to (or as a consequence of): d.						
r #3.	P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year				
Sortner			ompleted by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ဪ 0 3 ☐ Probably 4 ☐ Unknown					
28	I Records, The law requires I				24a. Was an autopsy performed 1 Yes 2					
lendy	ion of Vital	nding Physician: The ath. or: After this certificate ha funeral director, page	ertification: To Be	25. Was case referred to medical examiner? 1						
2	Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Suicide 6 Could not be determined 6 Could not be determined 5 Suicide 6 Could not be determined 6 City or Town, State) 5 Suicide 6 Could not be determined 6 City or Town, State 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 6 City or Town, State 7 Suicide 7 Suicide 8 Suicide 8 Suicide 8 Suicide 9 Suicid							
		To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
	,	To the within 2 To the complet	N N	29b. Signature and title of certifier 29c. License number D 1 8 487	29d.	Date signed (Month; Day, Year)				
	4	21'		30. Name and address of person vibrocompleted cause of death (Item 23a) (Type, Print) MYO TIHANT 602 S. ATWOOD RUAD, BELA	HR, MD	21014				
		Sta Registi		MYO TIHANT 60 2 S. ATWOOD RUAD, BELA 31. Date filed (Month, Day, Year) JAN 2 6 2005 Stewn & Species	,					

			1 - State Registrar	State of Maryland /		ment of Health and N iicate of Death		ene2005	01825
	Physici	an	1. Decedent's Name (First, Middle, Last)	BeeR	, , .		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	KOSA 4a. Facility Name (If not institution, give s			o. City, Town, or Location of Death	JAN á	0 2005 4c. County of Death	9:30 AM
	Examin	er	A 11 -	TWOOD AVE		BALTIMORE		10. Southly St Boats	1/A
	Funeral Director		17/10/1001	M 20 F 7. Age (In yrs. last		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, MAY 27	Year) Cou	place (State or Foreign intry) TZ-R/APD
	yland yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Locati	on			10d. Inside City Limits
	e Mar	ctor	MD NI	A	B	ALTIMORE			1 Yes 2 □ No
	with th	Funeral Director	10e. Street and Number 3037 FIEET	wood Ave		2 (2 14	10	g. Citizen of What Cou	
	death ms 23	nera	9.0	2. Was Decedent Ever in U.S.	13. Was	Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show pay injury or other traumatic event, the Medical Evaluation in and Le notified and page.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		s, specify Cuban, Mexican, Puerto Yes 3 No Specify:	Rican, etc.)	Black, White	hite
5-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation 16 completed)	(Give kind	's Usual Occupation of work done during most of work	ing 1	6b. Kind of Business/li	ndustry
72	l withir lene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	IITO. DO	Homemaker		Home.	
	al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last)		-	18. Mother's Nam	e (First, Middle, M		
Maryland	should b nd Ment marked umatic e	To I		CHAMA		ELISE	luyss		····
Ma	nd 2 sh lith and 27 Is n trauπ		19a. Informant's Name/Relationship (Type)			Goress (Street and Number or Run FleeTwood A			
Je,	ss 1 and of Health item 27 other to		20a. Method of Disposition	20b. Place	of Dispositio			Oc. Location - City or T	
Baltimore,	Pages ment of I ant: If its ury or o	J.	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	View	crematory 12		Bolto. No	
Ball	permit. Departn Imports any inju		21. Signature Funeral Service License	Stella	22. Na HA 75	ATTIEN MILLEN - S	BA ito.	WO 21234	ome cHD
II.			23a Part . Enter the disease, or complice shock, or heart failure. List only on			and the same of th		st,	Approximate Interval Between Onset and Death
ä	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			EART FAILL	IRE		YEARS
	Examiner			Due to (or as a consequence	ce of):				
	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ce of):				
	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
8760,	icate be executed physician and s the burial-transit	dical E	d	(
9	rtificat ng phy e as th	Medi	IF FEMALE:	9.77					
Box	that the death certific ed by the attending p detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy		opic pregnancy		23d. Date of deliv	ery Day Year
o.	the de by the dached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗆 Oti	ner (specify)	-/		
ds, P	es gu	d by Physiclan/Me	Part II. Other significant conditions con	ributing to death but not resulting	g in the under	lying cause given in Part I.	23e. Did toba	cco use contribute to t	
Vital Record	ne taw requir has been si ge 2 should	Completed					24a. Was an	24b. Were auto	opsy findings available
ž		Com					autopsy performe 1 ☐ Yes	death?	2□ No
Vita	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:			Check on one		-
	ding Phys h. After this funeral di	\vdash	1 Yes 2 No	THE RESERVE OF THE PARTY OF THE	o. Time of	Other: 4 Nursing Ho 28c. Injury at Work?	me 5 Residen 28d. Describe how		(fy)
sior	Attending ir death. ector: After by the funer	catlo	1 Natural 5 Pending 2 Accident investigation	(INOTILI, Day 16a)	Injury	M 1 Yes 2 No			
Division of	or Att after de Direct	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, building, etc. (Specify)	farm, street,	factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier 12 Certifying Phys	cian: To the best of my knowled	dge, death oc	curred at the time, date and place,	and due to the cau	se(s) and manner as s	stated.
	the Ho hin 24 the Fi	Medical	one)	and manner stated.	and/or invest	gation, in my opinion, death occurr			
	5 1 1 5 P		29b. Signature and title of certifier	Peresus		29c. License number 29c. 24952	290	I. Date signed (Month,	Dey, Year)
	1		30. Name and address of person who cor		a) (Type, Prin				
	O'		JOHN TIEVEL	USUD 76000:	SLER	DRIVE SUITES	08 Tows	SOW, MARY	AND 21206
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	J. A	DRIVE SUITEZ			

			State of Maryland / Department of Health and N 1- State Registrer State of Maryland / Department of Health and N Certificate of Death	Mental Hy	•	01020
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Bobbie L. Bankston	2. Date of Dea	20 ^{pay} 2005	3. Time of Death 12:45 PM
	Examir Funeral	ner	CIVISTA MEDICAL CENTER LA PLATA, MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year H Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl	CHARLES	
•	Director wows	J.	426-50-8753 76 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Mar. 2		S . 10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	atter death with the Maryland or Items 23e or 28a-f show niner rust be notified at	al Director	Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 2996 Eutaw Forest Drive 20603		10g. Citizen of What Co	ountry?
たか 036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Heatth and Mental Hygiene. If tiem 27 is marked other then "natural", or flems 23e or 28e4 show or other treumetic event, I're Madical Examinations in the Intifficial at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerton Cuban, Pu	pecify Yes or No- Dican, etc.)	Specify:	
K57	within 72 ho iene. r then "natur ine Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 2+ 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Piano Teacher	king	16b. Kind of Business	Industry
$\beta_{\alpha n}$	ould be filed Mental Hyg narked othe netic event,	To Be C	17. Father's Name (First, Middle, Last) James M. Allbritton 18. Mother's Name Mary Call	Lhoun	Maiden Sumame)	
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumetic event, IT. M. ODG.		19a. Informant's Name/Relationship (Type, Print) John D. Bankston-Husband 2996 Eutaw Forest Driv 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State)603
Bobbie Baltimore,	permit. Pag Department Importent: any injury o		4 Donation 5 Other (Specify) Griffin Cemetery 01/26 21. Signature of Funeral Service Licensee M00869 7601 Sandy Spring F	leck Fun		Inc.
B	Physician		2 (a. Part 1. Enter it. disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac shock, or heart fillure. List only one call so not chiline. Immediate the (Final disease or condition resulting in death) a. Pulmonary embolism			Approximate Interval Between Onset and Death
8760,	Medical Examiner physician and the purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			,
P.O. Box 68	The law requires that the death certificate tate has been signed by the attending physicage 2 should be detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes \ 2 \] No 9 \[Unknown \] 23c. If yes, outcome of pregnancy 1 \[Live birth \ 2 \] Fetal death 3 \[Ectopic pregnancy 5 \] Other (specify) \[9 \] Unknown		23d. Date of del Month	very Day Year
	v requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
tal Reco	ilcien: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical 26 Place of Deat	24a. Was a autops perform	med? death? 2⊠No 1 ☐ Yes	topsy findings available completion of cause of
Division of Vital Records,	ding Phys h. After this funeral di	Certification: To Bo	examiner? 1 Yes 2 S No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street factory office	ome 5 Reside 28d. Describe he	ence 6 Other (Spec ow injury occurred	
Div	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		building, etc. (Specify) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the c	n, State) ause(s) and manner as	stated.
•	To the H within 24 To the Fi	Medical	2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of certifier H − 0 0 4 2 4 4 5	2	ate and place, and due	n, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIMENTAL, MICHAEL A., DO 601 POST OFFICE ROAD			
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland	-	tment of H			iene 005	01827
			1. Decedent's Name (First, Middle,					2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Mary Elizab	eth brown				Month	Day Year 22 2005	1:00 PM
	Examin		4a. Facility Name (If not institution,		1	b. City, Town, or	Location of Death		4c. County of Death	Λ
			ST. AGNE			BALT If Under 1 Year	IMDRE If Under 24 Hrs.	CITY	N/.	7
	Funeral Director		5. Social Security Number 217- 18 - 0734	3. Sex 7. Age (In yrs. la 1 ☐ M 25 ☐ F		Months Days	Hours Min.	8. Date of Birth (Month, Day,	rear) Cour	place (State or Foreign ortry)
			Usual Residence of Decedent		32-			103.17.	1722	
	yland		10a. State 10b. County	I A 10c. City	, Town or Loca				1	0d. Inside City Limits
	the Maryland r 28a-f show notified at	ctor	MD N	14	Bal	timore				1 StYes 2 No
	ith th	Dire	10e. Street and Number	0 1		10f. Zip Code	0	10	og. Citizen of What Cour	ntry?
	ous after death with the Maryland el', or Items 23e or 28e-f show Exantine must be collified at	Funeral Director	925 Kevin	Koad			224		USA	
	ltem:	ine	 Marital Status Never Married 2 Marrie 	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Wa	s Decedent of Hi es, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	irs af	by F	3 SWidowed 4 □ Divorced	d 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	10	Yes 25 No	Specify:		Specify: BL	1CK
ŏ	filed within 72 hours after Hygiene. ither than "naturel", or Ite ont, I'm W. dical Exan		15. Decedent's	Education	16a. Deceder	it's Usual Occupa	ition		16b. Kind of Business/In	dustry
7	thin 7 e.	pie	(Specify only highest Elementary/Secondary (0-12)	Coilege (1-4or 5+)			uring most of work	ring	Retai	1
7	ed wi	Completed	12th grade	NA		Dresse			, , , , ,	
pu	tal H	Be	17. Father's Name (First, Middle, L.	ast) UNK			18. Mother's Nam	e (First, Middle, M	faiden Sumame) UN	K
Maryland 21215-0036	should be nd Mental marked c	ပ္	10a Informantia Nama/Dalatianahi	o (Time Grint)	105 14-15	1 dd (011		-10- 1-11	0. 7 0. 7	
a N	d 2 s th an th an treur		Proseule II A T	ackson. Nephew				altimore	City or Town, State, Zip	Code)
<u>ق</u>	1 and Health tem 27		20a. Method of Disposition	20b. PI	lace of Disposit	on (Name of			20c. Location - City or To	own, State
ē	Pages nent of I int: If its		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		emetery, crema BUTVS	tory`or other place		1	3AUO · MO	
Baltimore,	permit. Pages 1 and 2 should be filed withir Deportment of Heath and Mental Hygiene. Important: If item 27 Is marked other than any njury or other treumetic event, the Mones.	l i	21. Signature of Funeral Service	K //		lame and Addres	1			
ä	e and be		17 augh		Se	Baltimo	reene t	uneval se	rices ltimore MD	21279
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the death	. Do not enter	the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Priysician	d IV	Immediate Cause (Final disease or condition	CONGE	STIV	E HEA	OT F	ALURE	-	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequ		- 1167	ACT I	TILVERE		TIONRS
	Examiner.		Sequentially list conditions,		ZRONA	RY A	RTERY	DISE	ASE	HOURS
Ju -	ed sit	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		- 34		2	0.7.0	V-
. (cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ		NSIDM	420	DIAB	EIES	TEARS
8760,	sician burië				·					
687		edicai		d						
E SX	eath certif attending for use a	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal					23d. Date of delive	ery
B.	death	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		ctopic pregnancy other (specify)			Month	Day Year
70.	at the by the	hy	9 🗆 Unknown							
5,	res that the de igned by the a be detached f		Part II. Other significant condition	A					acco use contribute to the	
£ ps	v require been sig should b	ted	- PORIPHO	ZAZ VASCUL,	AR	DISEAS	<u>E</u>	1 Ye	s 2 10 No 3 Prob	ably 4 Unknown
MAA. Records,	2 8 0	ompieted	CHRONIC	ATRIAL	FIBRI	LLATIE	2~	24a. Was ar autops	y prior to co	psy findings available mpletion of cause of
<u> </u>	en: The tificate has or, page	Sol						perform 1 Tes 2	death? 1 ☐ Yes	2 🗆 No
ROMM, Division of Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	·	Othe		th (Check only one		
7 5	Phys r this ral di	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Larinpatient 2 □ I	ER/Outpatient 28b. Time of	3 DOA 28c. Injury		ome 5 Reside 28d. Describe ho	nce 6 Other (Specif	y)
ROW M	Attending Fir death. ector: After by the funera	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		Injury	Work	?Î (es 2 □ No	200. 0000100 110	Wallary occurred	
O.V.	l or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could no	ot be	me, farm, stree	t, factory, office		28f. Location (Str	reet and Number or Rura	l Route Number,
Q is	i di i	Certification:	4 Homicide determin	building, etc. (Specify	1)		1	City or Town	, State)	
0	ospit hours unera ly fille	cai (29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my know	wiedge, death o	ccurred at the tim	e, date and place,	and due to the ca	use(s) and manner as s	ated.
- 	To the Hospitel or within 24 hours af To the Funeral D completely filled in	Medicai	one)	xaminer: On the basis of examinat and manner stated.	uon and/or inve					
	To To To To To To To To To To To To To T	N	29b. Signature and title of certifier			29c. License			9d. Date signed (Month,	
	1		Acor	DR.		P	18619	7	JAN-22	- 2005
	10			the completed cause of death (Item		int)			JAN-22 , BALTI	
			ISMANLA JIE 31. Date filed (Month) Day, Yearh	BRIN, ST.	AGNE	5 +11	tal IM	CARE	, 046/1	MORE
	Sta Regist		31. Date filed (MANN 02), 6 ar2	Registrar's Signs	1500					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiege

			1 - For Stete Registrar		ertificate of Death	Reg. No.	05 01828
	Physici	an	1. Decedent's Name (First, Middle, La	ast)	BROWN	2. Date of Death Month Day	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Death	1-22-E	15 J. 48 M. nty of Death
	Examin	er	TOHN HOOK	ins Hospital	Paltimore)	my or Death
	Funeral Director			Sex 7. Age in yrs. last birthday,) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	D.	6	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L		0-1-10	Margians
	Maryla f sho	JO.	M D	D. 11	_		10d. Inside City Limits 1 XYes 2 □ No
	or 28e	irec	10e. Street and Number	DUATII	nore 10f. Zip Code	10g. Citizen	of What Country?
	ath wit	Funeral Director	2250 (ecil	Avenue	21218	(15	A
	ter de	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	Race - American Indian, Black, White, etc.
5-0036	72 hours after death with the Maryland netural', or Items 23e or 28e-f show ileal Esaminer must be notified at	l by F	S. Widowed 4 □ Divorced	1 □Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Yo Specify:	Spe	Black
15-0	"netu	Completed by	15. Decedent's E (Specify only highest gr	ade completed) (Give	edent's Usual Occupation e kind of work done during most of working	ng 16b. Kind of	f Business/Industry
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Mar	C1 42 70 90		19a. Informant's Na e/Relationship	(Type, Print) 19b. Maili	ing Address (Street and Number or Rura	I Route Number, City or To	wn, State, Zip Code)
Je,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Disp	osition (Name of Dimatory or other place)	ate 20c. Location	on - City or Town, State
Baltimore	permit. Page Department o Importent: If any injury or once.		1 Burial 2 □ Cremation 3 [— 4 □ Donation 5 □ Other (Speci	_Removal from State	Forest one on IL	31/05 QUI	OSMILS.MI
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	Physician		shock, or heart failure. List only Immediate Cause (Final	M . I . I . I	1	respiratory arrest,	Approximate Interval Between Onset and Death
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P.0	w requires that the death ce been signed by the attendi should be detached for use	Physician/	9 Unknown	9□ Unknown			
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of V	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 C	Other (Specify)
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	To the Hospitel or Attending Physicien: The lav Within 24 buours after death. To the Funorel Director Atter this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a restigation, in my opinion, death occurre	nd due to the cause(s) and ad at the time, date and plac	manner as stated. e, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and the of certifier		29c. License number	_	ned (Month, Day, Year)
	1		NE NE	DICAL DOCTOR	ees-ppg	JANUA	27 25,2005
	8		30. Name and address of person who	completed cause of death (Item 23a) (Type,	,		
	Sta	te	31. Date filed (Month, Day, Year)	NUICTY WOLFE STREET 32. Registrar's Signature 2005	BALLINORE MARYL	AND 2128+	
	Registr	ar	JAN 4 6	LUUD Blown St.	Gode		

	1	State Registrar			Certifica	ate of L	Calli	-		eg. No.		
ician		1. Decedent's Name (First, Middle, L						2.	Date of Deat Month	Day	Year	3. Time of Dea
dical		Helen Joseph Ja. Facility Name (If not institution, gi		owning	4h Cit	ty, Town, or I	l ocation of		nuary	22,	2005 County of Death	6:15 pm
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OI.	-	Usual Residence of Decedent		76				Ma	y 16,	1928	Mar	yland
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The initial dependence of the control of the contro		ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26 UD LIBERTY HEICHTS AVENUE KALU UMA, MD WESTSIDE MEDICAL GRUP BALTIMORE MD 21215 State 31. Date filled (Month, Day, Year) 32. Pegistrar's Signature		the I	Med	and manner stated.				
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			For State Registrar	State	of Mai	ryland / Depa <i>Ce</i>	artment of H rtificate of L		nd Mental	Hygie Reg.	200	15	01831	
			1. Decedent's Name (First, Midd	tle, Last)					2. Date Mont	of Death		Year	3. Time of Death	_
	Physici /Medic		Luther (Gibson Bla	ckis	ton, Jr.					Day 200		17:38 ^M	
1	Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of [4c. County of			
			2411 Derby I	rive			Falls	ton			На	rfor	df	
	Funeral Director		5. Social Security Number 218-48-6919	6. Sex 1 X M 2 ☐ F	7. Age	(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mon	of Birth th, Day, Ye 23 ,	1946 M		ce (State or Foreigr y) and	1
	pu 🛌		Usuel Residence of Decedent 10a. State 10b. Count	·		10c. City, Town or Lo	postion					100	1 Incide City Limite	_
	sho	7	Maryland Hari			Fallston						100	d. Inside City Limits 1 ☐ Yes 2∑ No	
	28a-f	Director	10e. Street and Number	LOIG		Tairscon	10f. Zip Code			100	Citizen of Wh	Count		_
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	ns 23	erai	2411 Derby I	Drive 12. Was De	cedent Ev	ver in U.S. 13.	2104 Was Decedent of Hi		12 (Specify Yes	or No-	USA 14. Race		n Indian.	_
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show digal Exercit at most be notified at	by Funeral	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 💆 Divorce	Armed F	Forces? 2 TyNo Sive		If Yes, specify Cuba 1 ☐ Yes 2 XNo	n, Mexican, F Specify:	Puèrto Rican, et	c.)		, White, et	C.	
Q Q	n 72 hou "natura		15. Decede	ent's Education		16a. Dece	dent's Usual Occupa	ation		161	o. Kind of Bus	Whi- iness/Indu		-
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b	e filed v Il Hygie other i vent, th	BeC	17. Father's Name (First, Middle	e, Last)		Acco	TICY	18. Mother's	Name (First, A					_
Maryland	Mer	To B	Luther Gibson 19a. Informant's Name/Relation	on Blacki	iston		ng Address (Street a	Franc	,		Bento		Code)	
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ē,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition			20b. Place of Dispo	osition (Name of		Date		. Location - C			-
9	0 0		1 ☐ Burial 2 【XCremation `4 ☐ Donation 5 ☐ Other		n State	Hilltop	matory`or other plac	. 1	-25-05	тс	owson,	Mary	land	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	e Ligensee?	.)	Mc	2. Name and Addres Comas Fun	ss of Facility eral H	Iome			_		
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ı	December.		shock, or heart failure. Li Immediate Cause (Final	st only one cause of	each line		11-	L .1	~			1	nterval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a	o (or as a	consequence of):	HEAL	رن 7	1 sea	re		1h	med (_
3	Examiner	ı).	40	exten	500						113	
		ner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	Due to	o() falsa	consequence of):	1						7:7-	
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9	ertific ling p	(a)	IF FEMALE:											-
O. Box	that the death certificated by the attending posterior of detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 gnant at t	Fetal death 3	□Ectopic pregnancy □ Other (specify)				23d. Date Mont		r day Year	
s, P	o o	by	Part II. Other significant condi	tions contributing to	death but	t not resulting in the t	underlying cause give	en in Part I.	23e	Did tobac			cause of death?	
Record	w requir been si should	ete							24a	. Was an	24h W	ere autons	sy findings available	_
al Re		Completed							_ _	autopsy performed Yes 2	d? pri	or to comp ath? Yes 2	oletion of cause of	
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Division	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Pla	ce of Inju	ry - At home, farm, si			28f. Loca	tion (Stree	t and Number	r or Rural F	Poute Number,	
<u>S</u>	af or after	Certification;	4 Homicide	bui	lding, etc.	(Specify)			City	or Town, S	State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certific (Check only one) 2 Medic	ying Physician: To t al Examiner: On the	he best of basis of anner stat	examination and/or in	th occurred at the tin	ne, date and pinion, death	place, and due occurred at the	to the caus time, date	e(s) and man and place, ar	ner as stat nd due to ti	ed. he cause(s)	_
	To the within To the comple	Me	29b. Signature and title of certification	2//	7		29c. License	e number	76	29d.	Date signed	(Month, Da	ay, Year)	_
•	15		30. Name and address of person	on who completed ea	Ne de grande	ath (Item 23a) (Type	Print)	28	27	10	1/17	7:0	201	
	St	ate	31. Date filed (Month, Day, Yea	Court 1 ar) 32	. Regista	r's Signature	770	1 On	SON	ju	10	210	86	
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amend i tem#7,8 perfff, 6840, 2/4/6 Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Marie Lucille Betsworth January 2005 23:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner de Grace Harford Memorial Hospital Havre rford . Age (In yrs. last birthday, 8. Date of Birth 7/9/1922 Birthplace (State or Foreign (Month, Day, Var) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🔀 F Director 521-24-3193 82 83 1921 Colorado Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Edgewood 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 636 Hornbeam Road or Items 23a 21040 USA Funerai 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify by 3 Widowed 4 Divorced natural White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) jes 1 and 2 should be fill of Health and Mental H Joseph Earl Bargas, Sr. Dena (nmn) Trujillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 636 Horrobean R1., Edgewood, MD 21040
Date 20c. Location · City or Town, State Huskand Harold Bargas Betsworth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 1-27-05 Bel Air, Maryland 21. Signature of neral Service Licenses 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part1. Enter the disease, or complications that caused the denth. Do not enter the mode of dying, such as cardia, or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Examiner burial-transit Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying of yse givenyin Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 Tyes 25 Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural
2 Accident 5 Pending investigation М 1 Yes 2 No death. after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title o 34022 January 24 2005 Do Frac address of person who completed cause of death (Item 23a) (Type, Print) 1308 Rusiness Center Way, Edgewood, MD 21040 Peter LoPresti 32. Registra s Signature 31. Date filed (Month, Day, Year) State JAN 2 6 2005

DHMH 17 Rev 1/2001

Registrar

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miner	Maryland Ge	noval de o	Hal	Balt: Mars	City	4c. County of Death	
eral tor	216-22-3164	6. Sex 1□ M 2∑F	ge (In yrs. last birthda 73 Yrs.	Months Days Hours	r 24 Hrs. 8. Date of Birth Min. (Month, Day,) Aug 3,	(ear) 9. Birthpli Count	ace (State or Foreity) U:
4	Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. City, Town or	Location		10	Od. Inside City Limi
tor	MD		Baltim	ore			1X Yes 2□N
Be Completed by Funeral Director	10e. Street and Number			10f. Zip Code	100	. Citizen of What Count	ry?
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Funeral	11. Marital Status	12. Was Decedent		 Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 	rigin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - America Black, White, e	
by F		If Yes Give	unk	1 ☐ Yes 2 No Specify	r:	Specify: b	lack
Completed	15. Deced	ent's Education rest grade completed)	16a. De	cedent's Usual Occupation	st of working unk 16	b. Kind of Business/Indi	ustry
nple	Elementary/Secondary (0-12		lite	ve kind of work done during mo. b. DO NOT use retired)	st or working GIIK		un
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o Be		s, <i>Lasi</i>)		unk 18. Moth	ner's Name (First, Middle, Ma	iden Sumame)	un
T _o	19a. Informant's Name/Relatio	nship (Type, Print)	19b. Ma	uiling Address (Street and Numb	per or Rural Route Number, (City or Town, State, Zip (Code)
	Maryland Gene	ral Hospital		7 Linden Avenue			/
J	20a. Method of Disposition		200. Place of Dis	position (Name of rematory or other place)	Date 20	c. Location - City or Tow	vn, State
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once	21. Signature of Funeral Service	D. Pleasant		22. Name and Address of Facil			
a	Unthony	Leasan		State Anatomy Baltimore, MD	30ard 655 W. 1	Baltimore Si	treet
	Shock, or heart failure. L	or complications that cause ist only one can be one of a	d the death. Do not a	enter the mode of dying, such as		1. 1	Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #2 PER DVR G839 1727/105 JH 2. Date of Death Month **Physician** nowar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pal-hmore
If Under 1 Year If Under 24 Hrs. Medical CA 5. Social Security 8. Date of Birth 0 (Month, Day, Year) 0 Ct. 28, 1945 Numbe 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 213-76-6454 1 → M 2 □ F 59 Yrs. India Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "netural", or Items 23e or 28e-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Director MD Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8007 Greentree Ct. 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divarced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) State Government Auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be A.P. Chowdry Dipti Chatterjee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any Injury or other trau <u>once</u>. Supriya Chowdry/Wife 8007 Greentree Ct. Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State Balt.-Wash.-Crematory1-17-05 Laurel, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature | Funeral Service Licensee 7601 Sandy Spring Rd. Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metasano TENCIL Lell Caramona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 100 1 Yes 2 \ No 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending within 24 hours after deam.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/15/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Staté

Registrar

Ke I hour

32. Registrar's Signature

Street

31. Date filed (Month, Day, Year)

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				ate of Maryland /	Depa	artment	t of He	ealth a		_	_	ne.	01005
			= State Registrar		Cer	tificate	e of L	eath			g. No. C	0.0	01835
ı	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) LEON CC	LEMAN					1/1	Date of Death Month OM MO	Day	Year 2005	3. Time of Death
	Examin		4e. Fecility Name (If not institution, give stree		AL	4b. City,	Town, or	Location of	Death I		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Sex 150_38-7459 15M	7. Age (In yrs. last)	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8. (Min, 03	Date of Birth Month, Day, 28	^{Year)} 29	9. Birthpla Count SC	ace (State or Foreign ry) C
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation						10	d. Inside City Limits
	the Ma 28a-f s	Director	MD NA 10e. Street and Number	Balt	imo	re 10f. Zip	Code			10	og. Citizen of V	Vhat Count	1 X Yes 2 □ No ry?
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98	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland atrunent of Heatih and Mental Hyglene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, I're Medical Erain at must be notified at injury or other traumatic event. I're Medical Erain at must be notified at 8.	by Funerai	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. umed Forces? ☑ Yes 2 ☐ No 'Yes, Give	1				gin? (Specify , Puerto Rica	Yes or No- in, etc.)	14. Race	e - America k, White, e	
Ö	thours	ed b	15. Decedent's Educatio	n 16	6a. Deced	lent's Usua	il Occupa	tion		1	6b. Kind of Bu		
Baltimore, Maryland 21215-0036	within 72 ine. ihan "ne a Medic	Completed	(Specify only highest grade cor Elementary/Secondary (0-12)	college (1-4or 5+)	life. L	kind of wor DO NOT us D riv	e retired)	uring most	of working	p	etH S	امما	Corp
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ylar	should be nd Mental marked c	ToB	Edward Coleman						a Col				
Mar	d 2 sho th and 7 is my traum		19a. Informant's Name/Relationship (Type, I								City or Town,		
Je,	of Health of Health litem 27		DeboraH Dickerson 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo	20b. Place	of Dispo	sition (Nam natory or ol	ne of		Date	, Dal	Oc. Location -	City or Tov	wn, State
ţ	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe		'4 □ Donation 5 □ Other (Specify) 21.(Si nature of Funeral Service \ cepsee	Garr:						8/05	Owing	s Mi	lls, Md
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\	S D	To B	examiner? 1 Yes 2 No Hosp	ital: 1 Inpatient 2 ER/	Outpatien	at 3 🗆 DO	A Othe	^{IC} 4 □ Nur	rsing Home	5 🗀 Reside	nce 6 Oth	er (Specity,)
	ffer ng		27. Manner of Death 2 1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	b. Time of Injury	M .	8c. Injury Work 1 Y	at ? ′es 2 □ N		Describe ho	w injury occurr	ed	
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Sertification:	3 Suicide 6 Could not be determined 2	8e, Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory	, office		28f.	Location (Str City or Town	reet and Numb , State)	er or Rurai	Route Number,
	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	(Check only 2 Medical Examiner:	in: To the best of my knowled On the basis of examination and manner stated.									
	To th withir To th comp	Me	29b. Signature and title of certifier	, cruz	- in		License D		0355		anno		
	3+1		30. Name and address of person who complete R. CS/FA R.	(P117 M	A	Print)	BOR	Y S	ECC	ours	Hos	spit	20 2005 AL
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005ar **Physician** Jan. 5:00 p Mary Emma Cheshier /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 23, 1924 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Min Days Hours 1□ M 2 1 F 217-18-8516 80 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County or items 23a or 28e-f show other traumatic event, the Medical Examinary ust be notified at 1 Yes 2 No Carroll Manchester Maryland **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21102 U.S.A. 2501 Mt. Ventus Rd. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 → Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laundress Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental I ont: If item 27 Is marked of Gertie May Shaffer Wesley Edward Calp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4628 York Rd. #1, Manchester, Md. 21102 James A. Cheshier Jr. - son Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) jo = 0 1 Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If any injury or Evergreen Mem. Gardens Jan. 26,2005 ' 4 ☐ Donation 5 ☐ Other (Specify) Eckhard Address of Facility 3296 Charmil Dr. 21. Signature of Fugeral Service Licensee Chapel P.A. Elles Manchester, Md. 21102 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical quence of): **Examiner** Sequentially list conditions Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year ō in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 № No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes of Vital to the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Propatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Certification: After Injury Division 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. s after death. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel [1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier ofe Road, Westminster, mo 21157 of death (Item 23a) (Type, Print) 30. Name d address of person who 32. Registra trar's Signature Date filed (Month, Day, Year) State Registrar

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		_	State Registrar			Cei	tificate of l	Death		g. No. 👇 🔾 U	0 01031
		_	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Yea	3. Time of Death
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	edica		4a. Facility Name (If not institution, give stre			COLV		Location of Death	7	4c. County of De	
EXa	mine						Face			Daltim	0160 00
		4	Riverview Nursing 5. Social Security Number 6. Sex		a (In ure la	st birthday)	Esse If Under 1 Year		8. Date of Birth		ore Co.
Fune		1		1 212 F		Yrs.	Months Days	Hours Min.	(Month, Day, 1	1022 T7-	Birthplace (State or Foreign Country) Lrginia
Direc	tor	-	Usual Residence of Decedent	8.1	1				NOV. 27	,1923 V.	LIGINIA
pue *	20	- 1	10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
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N θε N		2	7				1.22			025	
ith ti		5	10e. Street and Number				10f. Zip Code			g. Citizen of What	
23a	1 3	ō	7710 Eastdale Road	1				2122			States
dea ama		ט	11. Marital Status	. Was Decedent E Armed Forces?	Ever in U.S	13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W	merican Indian, hite etc.
afte of			1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☑ No	Specify:		Specify:	,
72-00.30 72 hours after death with the Maryland "neturel", or Itema 23a or 28a-f show	1	2	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						эрвену.	White
2 hc		Collibrated	15. Decedent's Educa (Specify only highest grade of			16a. Dece	dent's Usual Occup	ation	ing 1	6b. Kind of Busine	ss/Industry
		2	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retired	during most of work f)	9		
d C C filed within Hygiene. other than		5	9 Years			Asse	embly Lin	e Worker		Western 1	Electric Co.
Hygi other		ע	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle, M	aiden Sumame)	Ukn.
d be ental		2	James	r	ralle	V		Eliz	abeth		
should be filed within and Mental Hygiene.	۱	-	19a. Informant's Name/Relationship (Type				na Address (Street	and Number or Run	al Route Number.	City or Town, State	a, Zip Code)
War d 2 sho th and 7 Is ma			Mr. Charles E. Co				•	ollar Way		ore, Mar	
ore, M es 1 and 2 of Health litem 27 I		-	20a. Method of Disposition		20b. Pla	8				Oc. Location - City	or Town State
MOCE, Maryland CIC Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Intil If least 271s marked other than more of the strength of the s	5	-	1 X Burial 2 ☐ Cremation 3 ☐ Rer	noval from State			sition (Name of matory or other plac				
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mit.	once.		21. Signature of Juneral Service Licensee	\sim $/)$	9	22 T	2. Name and Addre	ss of Facility Funeral	Home of	Dundalk.	Inc.
n aaes	9		Otream C	1/00			7922 Wise	Ave. Di	undalk, N	laryland	21222
6.01			23a. Part1. Enter the dise v e, or com lica shock, or heart fail List unly one	tions that caused	the death.	Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Dhyoici	an		Immediate Cause (Fin	//	wg	Como	- for	+			Onset and Death
Physici /Medi	_		disease or condition resulting in death)	Due to (or as	- 11	once of/:	- 10	1			2-3 mondy
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pg :		Examine	cause. Enter Underlying Cause (Disease or injury	220 10 (0. 40)							
ecut and		2	that initiated events c. resulting in death) Last	Due to (or as	2 CODERGU	ence of):					
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ate b aysic		Cal	d.								
The COTGS, P.O. BOX 68/	0	by Physician/Medi	IF FEMALE:								
BOX bath cer attendir	Pen I		23b. Was decedent pregnant 23c	. If yes, outcome 1 ☐ Live birth	of pregnar		Ectopic pregnancy	,		23d. Date of	
deat death	2	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)			Month	Day Year
the the	2	3	9 🗆 Unknown	9□ Unknown							
that the	9	2	Part II. Other significant conditions contr	ibuting to death b	ut not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did toba	icco use contribute	to the cause of death?
	2 1	0	Type II Die	esele.	0,	Al	Thein	ors.	1 🗌 Yes	2 □ No 3 □	Probably 4 Donknown
VITAI HECOFIAS, sicien: The law requires t certificate has been signed	0	ompieted				(De	mention	24a. Was an	24h Mara	autoney findings available
lec e law has	ט ס	du							autopsy perform	prior	autopsy findings available to completion of cause of 2
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T V		0	1 ☐ Yes 2 ☑ No Ho	spital: 1 🗌 Inpatie	ent 2 🗆 E	R/Outpatie	nt 3□ DOA Oth	er: 4 Mursing Ho	ome 5 Residen	ce 6 Other (S	pecify)
ding Physicien: The lav h. After this certificate has			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Describe how	v injury occurred	
		atic	2 Accident investigation					Yes 2 □ No			
DIVISION f or Attending after death. Director: After	n do	1 1 1	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc	ury - At hor	me, farm, st	reet, factory, office		28f. Location (Street, City or Town,	et and Number or	Rural Route Number,
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UNISION OF VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica			29a. Certifier 1 Certifying Physic	cian: To the best	of my knov	vledge, deat	h occurred at the tir	ne, date and place,	and due to the car	use(s) and manner	as stated.
24 P	:	edical	(Check only 2 Medical Examine one)	er: On the basis of and manner sta		ion and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and o	due to the cause(s)
o th		ĕ.	29b. Signature and title of certifier				29c. Licens			d. Date signed (Mo	
H 3 H	N C		MALON	M-D.			D	-387	54 0	01-18-	2005
11	/	-	IVVV	/ • · · /	1N ():	00*) (T	D-i-s)	/ `			
W.C.			30. Name and address of person who com	pleted cause of d		23a) (Type,	Print) P. A.S	TERM	BLVD	· MD	-21221
<u> </u>			31. Date filed (Month, Day, Year)	32. Regist		ure	11	* * *			
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_		For State Registrar 1. Decedent's Name (First, Middle, Last)	arylana /		artment of F rtificate of		2. Date of D	Reg. No.	005	0 1 8 3 8
Physici /Medic		Thomas J. Carroll					Month	Day 24	2005	
Examin Funeral Director	ier .	4a. Facility Name (If not institution, give street and number) VA Maryland Health Car 5. Social Security Number 212–18–3016 6. Sex 1XI M 2 IF			4b. City, Town, o Perry If Under 1 Year Months Days	Point If Under 24 Hrs. Hours Min.		Ce	ounty of Death ecil 9. Birth 911 Mar	n nplace (State or Foreign ly Tand
D	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, To		cation					10d. Inside City Limits 1 ☐ Yes 2 ☒No
th with the 23e or 28	Funeral Director	10e. Street and Number 2937 Edgewood Avenue			10f. Zip Code 21234			10g. Citize	n of What Cou	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any fujury or other treumatic event, the Marylad Examinate highlight at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Never Married 2 □ Married 11 □ Yes, Give Year or Dates:		ĺ	Was Decedent of High Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or N o Rican, etc.)		. Race - Amer Black, White pecify: Wh	
within 72 ho ene. then "netur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 n/a	5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king		of Business/I	·
uld be filled Mental Hygid Irked other Itlc event, III	To Be Co	17. Father's Name (First, Middle, Last) Thomas M. Carroll	Ser	rvice	Station Op	18. Mother's Nan			can Oil	Lompany
and 2 sho ealth and h n 27 ls me		19a. Informant's Name/Relationship (Type, Print) Kathleen Mooney-friend		2939	ng Address (Street Edgewood Av		imore, M			ip Code)
Pages 1 ment of H. ent: If iter lury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	cemete	өгу, сгөг	sition (Name of natory or other place National	1/28/	Date '05		tion - City or T timore, l	
permit. Depart Import any Inj		21. Signature of Funeral Service Licensee William	G. Dau	22	. Name and Addre	ss of Facility L				neral Home
Physician /Medical Examiner portion and portion in the property of the proper	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	•	e of): e of):						Interval Between Onset and Death
v requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medic	IF FEMALE: 23c. If yes, outcome	2 Fetal deat		Ectopic pregnancy	,		230	d. Date of delive Month	very Day Year
quires that on signed b uld be deta	ed by Pr	Part II. Other significant conditions contributing to death by Hypertension			nderlying cause giv	en in Part I.		tobacco use Yes 2 ⊠ 1		the cause of death?
: The law re cate has bee page 2 sho	Completed								24b. Were aut prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available ompletion of cause of 2 No
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. The Funeral Director and the this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatial 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	iry 28b.	Time of Injury	28c. Injun Wor	y at	ome 5 Resi	dence 6 how injury o	occurred	ral Route Number,
To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	cai Certi	4 ☐ Homicide building, et 29a. Certifier (Check only) 1 ★ Certifying Physician: To the best 2 ☐ Medicel Examiner: On the basis of	tc. (Specify) of my knowledd	ne. death	occurred at the tin	ne, date and place	City or To	wn, State)	id manner as	stated
To the H within 24 To the F complete	Medicai	29b. Signature and title of certifier	ated.	na or in	29c. Licens		neu at the time,		signed (Month,	
64)		30. Name and address of person who completed cause of c	,		Print)	094-1				1,2005
Sta Registr	- 4	Melecia Santos, M.D., VA 31. Date filed (Month, Day, Year) JAN 2 6 2005	ar's Signature			Care S	ystem,	Perry	y Poin	it,MD21902

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5, per Fri G839 1726/05 TI
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** CATHERINE GERTRUDE CAPLE JANUARY 24, 2005 1:10AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner LONG VIEW NURSING HOME MANCHESTER CARROLL 8. Date of Birth (Month, Day, Year) OCTOBER 5, 1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 220-62-6098 220-26-6098 Usual Residence of Decede 1 □ M 27 F MÄRYLAND 83 Yrs 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND CARROLL YSYes 2□No WESTMINSTER Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 216 EAST GREEN STREET 21157 UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes ŽŽŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes Long No Specify: Specify: Completed by 3€ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STERLING N. POOLE, SR. RUTH MARIE FARVER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) WESTMINSTER, MD JANET CAPLE/DAUGHTER 216 E. GREEN ST, 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 □ Cremation 3 □ Removal from State SANDY MOUNT U.M. CEMETERY 1/27/2005 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS ST, WESTMINSTER, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 90x > 20 consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 🗆 Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29c. License number

Hans ser

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29d. Date signed (Month, Day, Year)

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/Medical Examiner The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, paga 2 has certificate Hospital or Attending Physician: After death Director: / within 24 hours aft

To the Funaral Di

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Funeral

Director

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Important: If itam 27 is

Physician

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Pages 1 and 2 should ba filed within 72 hours aftar death with the Maryland

Baltimore, Maryland 21215-0020

State Registrar

29b. Signature and title of cartifier

31, Date filed (Month, Day, Year)

30. Name and address of

person who completed cause of death (Item 23a) (Type, Print)

2005

32. Registres Signature

1115

DHMH 16 Rev 6/95

			For State Registrar	State of Man		artment of F rtificate of			iene () () ()	5 01840
П	Dh		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
1	Physici /Medic		Beatrice COOK			T		January	20 200	05 10.20am M
	Examin	er	4a. Facility Name (If not institution, give si 3915 CALLAWAY AVEN				T Location of Death		4c. County of (Death
v	Funeral Director		5. Social Security Number 220-05-7585 6. Sex 1□	M 2□X 91	'n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02-25-1	Year)	Birthplace (State or Foreign Country) SC
	and		Usual Residence of Decedent 10a. State 10b. County	1.	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho	ō	MD N/A			TIMORE				1 ☐ Yes 2 ☐ No
	r 28a-	rec	10e. Street and Number		5111	10f. Zip Code		1	0g. Citizen of Wha	it Country?
	th with	alD	3915 CALLAWAY AVEN	IUE		21215	5		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examination in Item and Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Eve Armed Forces? □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. BLACK
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an	ld be ental ked o	To Be	BILL GILYARD				LEVE	ENIA HAI	R	
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number	, City or Town, Sta	te, Zip Code)
	and 2 salth s n 27 ls		MICHAEL COOK/GRAND	SON	5	935 RADEC	CKE AVENUE	E, BALTO	., MD 212	206
nore	ages 1. ant of He it: If iten y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			osition (Name of matory or other place ON Norial Pa	ce)	7 – 2005	20c. Location - Cit BALTIMOF	
Baltimore,	permit. F Departme Importar eny injur		21. Signature of Funeral Service License	Mut	2:	2. Name and Addre	ss of Facility JAN	MES A. MO	ORTON & S	SONS F.H., INC
			23a. Part1. Enter the disease, or complic	cations that caused th			RENS ST.,			Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final		3 ~ C					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	al Infarquence of):	ction				One Day
1	Examiner				Artery I	Disease				Years.
¥0	7 =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c						
	acuter ind transi	ami	Cause (Disease or injury that initiated events resulting in death) Last	Hyperten						Years.
8760,	cate be executed physician and the burial-transit	dical Examiner	leading in county cast	Due to (or as a d	consequence of):					
387		dica	d.							
.O. Box (that the death certificated by the attending posterior of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	y		23d. Date of Month	f delivery Day Year
s, P	8 7 9	by	Part II. Other significant conditions con Non Insulin Depend		•	, ,	ven in Part I.			te to the cause of death? Probably 4 Unknown
Record	e law has b	Completed	Degenerative Oste	o-arthriti	s			24a. Was a autops perform	ned? deat	e autopsy findings available to completion of cause of th? Yes 2 X No
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical				26. Place of Deat			
of V	8 m D	To	examiner? 1 ☐ Yes 2ઁ No	ospital: 1 Inpatient	2 ER/Outpatie		4 - Norsing Ho	me 5 Reside	ence 6 Other (Specify)
			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time o	Wor		28d. Describe ho	w injury occurred	
Sio	Attending r death.	icati	2 Accident investigation 3 Suicide 6 Could not be	28a Place of loius	At home form of		Yes 2 □ No	28f Location (St	reet and Number o	or Rural Route Number,
Division	tel or Atten rs after deat el Director: ed in by the	Certification;	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	rest, factory, office		City or Town		n riural rioute riumber,
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	edical		ician: To the best of ear: On the basis of ear and manner state	camination and/or in					
)	To the within 2 To the complet	Ň	29b. Signature/and title of certifier	all.	4	29c. Licens D 304			9d. Date signed (Manuary 2	Nonth, Day, Year)
	1 Sex		30. Name and address of person who co N B Vellanki, md, 9	mpleted cause of dea 0055 Chevro	th (Item 23a) (Type, plet Drive	Print) e, #Suite	100, Ell	icott Ci		•
40	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	0:					
	Registi	ell	JAN & 0	LUUJ PAGE	1000					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** KOBERT COLEMAN Davage 24 05 11:00 A M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL BALTIMORE UNION If Under 24 Hrs. 7. Age (In yrs. last birthday) 48 Yrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Months Days 9. Birthplece (State or Foreign **Funeral** Hours 220-64-5752 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Itams 23a or 28e-f show Examiner must be notified at BALTIMORE MD Yes 2 □ No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 930 N. PATTERSON PARK AVENUE U.S. A. 21205 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give " Year or Dates: Specify: BLACK 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use rained)

PUBLIC KELATIONS th and Mental Hygiene.

7 Is marked other than "nature treumstic event, the Medical 16b. Kind of Business/Industry PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be CHARLIE COLEMAN, SR. Ada JOHNSON of Health and N Item 27 Is ma other treums 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 925 N. PATTERSON PARK. BALTO, MO. 21205 LILLIE MILES (SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition o = 1/28/05 1 Burial 2 Cremation 3 Removal from State BAU (MORE , MD permit. Page Department of Important: If any injury or once. KING MEMORIAL PARK * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GEFENE PUNGRAL SCNS 21. Signature of Funeral Service Licensee 4905 YOCK ROAD. BALTMORE, MO. 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ineele disease or condition resulting in death) phenmonia /Medical Due to (or as a consequence of): Examiner SEDSAS Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a conquence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 0 Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1□ Yes 208 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 2 1 ☐ Yes 2 ☐No 1 Nopatient 3 DOA this funeral 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier fixertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D0053617 Wasser, 5005 WD HASSOLY Janvary 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSSON MOSSY ZOI East University Parkway Ballingue, MD 21218 31. Date filed (Month, Day, Year)
JAN 2 6 2005 32. Registrar's Signature State ENECKE! Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of		d / Depa		t of H	lealth a				2000	01812
	•		Decedent's Name (First, Middle, I	Last)							2. Date of De	ath		3. Time of Death
г	Physicia		Corinne R. Co	nn							Month Januai	v 21	2005	0655 M
	/Medic Examin		4a. Facility Name (If not institution, g		oer)		4b. City,	Town, or	Location of	of Death			County of De	
	_Aq.	Ψ,	Montgomery Gene	ral Hospi	tal.		01r	ney				Mo	ntgome	ry
10	. Funeral			. Sex 7.	Age (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min,	8. Date of Bil (Month, Da	th		irthplace (State or Foreign Country)
	Director		067-16-9329	1□M 2XF	82	Yrs.	World	Days	Tiouis	IVIII I,	June 1	4, 1	922 Nei	w York
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Aaryik f eho	ō												1 □ Yes 2X No
	28e-	rect	Maryland Montgom	ery	51	lver S	10f. Zip					10a Citi	zen of What C	Country?
	with 3a or	ΙD	14536 Kelmscot	Drivo				906					ed Sta	•
	ms 2:	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.	.S. 13.			ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Am	nerican Indian,
ပ္	or ite	Fur	1 Never Married 2 Married	Armed Forc	X No					i, Puerto	Rican, etc.)		Black, Wh	ite, etc.
9	within 72 hours after death with the Maryland ane. then "naturel", or items 23a or 28e-f ehow he Medical Examination notified at	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 Tes 2	X No	Specify:				Specify:	hite
20	72 honatu	Completed	15. Decedent's (Specify only highest of			16a. Deced	dent's Usua kind of wor DO NOT us	l Occupa	ation during mos	t of worki	ina	16b. Ki	nd of Busines	s/Industry
21	ithin ner Mer	ηdμ	Elementary/Secondary (0-12)	College (1-4	or 5+)									
2	fygiel Her tl		12 17. Father's Name (First, Middle, La	G#)		Tax	Accou	inti		rla Nama	(First, Middle	_	counti	ng
Maryland 21215-0036	l be fi	Be	Aaron Roth	51)							elson	, ivialderi	ourname)	
Z	hould d Me mark matic	은	19a. Informant's Name/Relationship	(Type, Print)		19h. Mailir	ng Address	(Street a			d Route Numb	er City o	r Town State	Zin Code)
	alth ar 27 Is r trau		Katie Phillips/				_				Kensing	-		
ē,	f Hea f Hea item othe		20a. Method of Disposition		20b. P	Place of Dispo cemetery, crer				70.0	ry 23,		cation - City o	
E	Pages nent of I ent: If its ury or o		1 ☐ Burial 2 🖾 Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		Mor Cre	ntgomer ematori	y i i m	ne piac	1	20		Bet	hesda.	Mary1and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28e-f ehow ampropriant: If item 27 is marked other than "naturel; or items 23a or 28e-f ehow ampring yor other traumatic event, the Medical Examinate must be notified at once.		21. Signature of Funeral Service Un	ensee		22	2. Name an	d Addres	s of Facilit	Rob	ert A.	Pump	hrev F	uneral Home/
	89 2 2 9		Birdy	eny	_ M008	303 R	ckvi]	1e,	Mary	land	Westo-	2865	omery	Avenue
	2 J		23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that cally by one cause on each	ised the deat th line.	h. Do not ent	er the mode	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
H	Pnysician		Immediate Cause (Final disease or condition	_a	sehro	vascul 1	us c	رودز	dent					Onset and Death
	/Medical Examiner		resulting in death)		as a conseq		1							
	_ A	-	Sequentially list conditions,	b. Due to (or	as a conseq	fr Pi	114	けいし	^					
	nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	'	rtena	2000							1
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
760,	ate be executed nysician and he burial-transit	cal		d										
89	tifical ng phy as th													
Вох	death certifica e attending ph d for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 □ Feta		Ectopic pro	agnancy				2	3d. Date of de	,
E		Physician/Med	in the past 12 months? 1 ☐ Yes 2 MNo		nt at time of d		Other (sp						Month	Day Year
P.O.	at the	Phy	9 Unknown		4b b b	. (6)					an- pida			to the cause of death?
	ires the signer	by	Part II. Other significant conditions						24 50			Yes 2		Probably 4 Unknown
Orc	w requires that been signed be should be det	etec		, , , , , , , , ,	100	13000	1	3(5	1430		-			
3ec	e la has je 2	Completed									24a. Was auto perfo		prior to death?	tutopsy findings available completion of cause of
a		e Co	25. Was case referred to medical								1 Tes	2 No	1 □ Ye	s 214 No
⋚	Physiclen: this certifical director,	8	examiner?	Hospital: 1 Inp	ationt 2	ER/Outpatien	3 7 00	, Othe			n <i>(Check only o</i> me 5 ☐ Resi		Other (C-	anifed
of		n: To	27. Manger of Death	28a. Date of (Month,		28b. Time of		Bc. Injury	/ at		28d. Describe			өспу)
ion	Attending r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigat		Day Year)	Injury	М	Worl	<br Yes 2. □ I	No				
Division of Vital Records,	ar dea ector	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	f Injury - At ho	ome, farm, str	eet, factory	office			28f. Location (City or To			Rural Route Number,
Ö	rs after safter sell bir	Cerl									·			
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the b aminer: On the bas and manne	is of examina	wledge, death	h occurred a vestigation,	at the tim in my or	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. te to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier						e number					nth. Day, Year)
	11	6	- Juna	W.D	-			D5	74	81		Jan	vary 3	N1, 2005
7	0 1		30. Name and address of person wh		of death (Item	п 23а) (Туре,	Print)	,	0		1			Narylune 2043)
			24 Data filed (Month Day Vons)	M.D. 18	ictraria Sian-	VIN(C	hw'	10	DVIV	2 >	1te 50	40	inexive	rayland 0-331
A	Sta Registr		TRALE O A	2005	etrar's Signa	Le A	- هو د م							
DH	MH 17 Rev 1/20	- 100	JAN Z 6 2	בעוני	Color of	a so	SAL D							

ORIGINAL

			State of Maryland / Departn	•	
			a FOI	cate of Death	Reg. No. O O O F
	Phys	ician	1. Decedent's Name (First, Middle, Last)		of Death Day Year
	/Me	dical	000::-0	City, Town, or Location of Death	an 21 2005 6 A M 4c. County, of Death?
	Exar	niner	Mariner Health of Bel Air	Bel Air, Marylo	ind Hartord
	Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If 1	Under 1 Year If Under 24 Hrs. 8. Date on this Days Hours Min. (Months)	of Birth th, Day, Year) 9. Birthplace (State or Foreign Country)
	Direct	or	155-09-9853 15M 2 85 Yrs. Usual Residence of Decedent	Marc	ch 4, 1919 Iowa
	ryland		10a. State 10b. County 10c. City, Town or Location	n	10d. Inside City Limits
	he Ma 28a-f s	ecto	Maryland Harford Bel Air	N. T. O. J.	1 □ Yes 2 🙀 No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 2000 Helton Avenue	0f. Zip Code 21015	10g. Citizen of What Country? USA
	death	nera		Decedent of Hispanic Origin? (Specify Yes s, specify Cuban, Mexican, Puerto Rican, et	
Ω	Ind 21215-0036 ba filed within 72 hours after death with the Marylan tall Hygiene. Ind other than "natural; or itams 23a or 28a-f show event, the Medical Evans are must be notified at	by Fu	1 Never Married 2 Married 1 Wes 2 No Korea	res 🎾 No Specify:	Specify
11)	2 hour	ted t	15. Decedent's Education 16a. Decedent's	s Usual Occupation	16b. Kind of Business/Industry
16	215 ithin 7 ne. "n Medi	Completed	(Specify only highest grade completed) (Give kind life. DO N	of work done during most of working IOT use retired)	
2	d 212 filed with Hygiene ither tha	Cor	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N	U.S. Government
J			Cyril Balfour Clark, Jr.	Harriett	Mable Lawyer
7	0 0 0 0	0)		idress (Street and Number or Rural Route I	
	fe, M 1 and 2 Health tem 27 is		Vera Clark - Wife 2000 He 200. Method of Disposition 200. Method of Disposition 200. Place of Disposition cemetery, cremator	lton Avenue, Bel Air	20c. Location - City or Town, State
	Baltimore, I permit. Pages 1 and Department of Health important: If item 27 eny injury or other t		1 ➡ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) **Christ Ch.**		Hanna City, IL
	alti rmit. I spartm spartm sportal	9	21. Signatuse of Funeral Service Licensee 22. Nat	me and Address of Facility McComa	s Funeral Home, P.A.
	o 8455	ä		7 Cokesbury Road, Ab	
	Management		23a. Part. Enter the disease, or complications that, us—the death. Do not enter the shock, or heart failure. List only one cause ach the. Immediate Cause (Final	1	tory arrest, Approximate Interval Between Onset and Death
	Physicia /Medic		disease or condition resulting in death) a	10ma	() months
	Examin		Sequentially list conditions.		
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
P	760, te be executed ysician and te burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
	3760, ate be ex nysician he buria	cal			
1	Box 687 leath certificate attending physister at the second process.	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
$\overline{\lambda}$	Box death cert attendin d for usa	by Physician/Med	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ector in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Oth	opic pregnancy er (specify)	23d. Date of delivery Month Day Year
V	at the obtained the stached	hys	9 ☐ Unknown		
	I Records, P.O. Box 68 The law requires that the death certifica tee has been signed by the attending phi age 2 should be detached for usa as the		Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown
D	Record he law requir he has been s ige 2 should	letec		24a	Was an 24b. Were autopsy findings available
\rightarrow	Vital Rec sician The law s certificate has b	Completed		10'	autopsy prior to completion of cause of death?
0		BeC	25. Was case referred to medical examiner?	26. Place of Death (Check	
	of Vita Physician or this certific aral director	0	Hospital:		Residence 6 Other (Specify) cribe how injury occurred
	on Iding Ith. :: After	atlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work?	clibe now injury occurred
	Division I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office 28f. Loca City	tion (Street and Number or Rural Route Number, or Town, State)
	Dital o	Cer	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occ		
	Division of To the Hospital or Attending Physical Attending Physical Provis after death. To the Funaral Director: After this completely filled in by the funaral director and the completely filled in by the funeral directors.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occ and manner: On the basis of examination and/or investiged and manner stated.	palion, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			NE MO	D34652	Junuary 21, 2005
	let		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Scott Avin	1) 1	1947 And 21014
		State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Reg	istrar	IAN 2 6 2005 Reserve & Some	1.	

DHMH 17 Rev 1/2001

		1 - For State Registrar			Ce	rtificate	e of L	Jeath			Reg. No.	200	5	0184
Physici /Medio Examir	cal	Decedent's Name (First, Middle, L Vera Mildred DiPact Aa. Facility Name (If not institution, g Good Samaritan Hospi	ola tive street and number	er)		4b. City, T	rown, or Baltin			2. Date of De Month January	23, Day 4c.	2005 Yeal	ar	3. Time of Death
Funeral Director		5. Social Security Number 6. 217–16–3030 Usual Residence of Decedent		Age (In yrs. la 89	ast birthday) Yrs.		1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir Month, Da Decembe	th (26,	1915 ^{9. 8}	Birthplac Country Mary I	e (State or Fore and
ene. then "naturel", or items 23a or 28e-f show the Medical Examinar must be natified at	ector	10a. State 10b. County Maryland Baltimol	re		erry Ha		Code				10g Citi	zen of What		. Inside City Limi 1 ☐ Yes 2 🔏 î
s 23a or	erai Dir	9325 Perglen Road	12. Was Decede	ent Sver in 116	6 12	21	1236	aia Osia	-1-2 (C	-4. V N	USA	14. Race - Ar		
ırel', or item LExaminarı	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	Armed Force	es? □ X No	1	If Yes, specif		Specify:	, Puerto F	cify Yes or No Rican, etc.)		Black, Wi	hite, etc	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-f shov eny injury or other treumatic event, the Medical Examinar must be notiffied at once.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education grade completed) College (1-4d	or 5+)	(Give life.	dent's Usual kind of work DO NOT use Cry Chef	k done d e retired)	ition lu <i>ring m</i> ost)	of workin	g		imore C		
and Mental Hygiene. Is marked other then eumatic event, the Me	To Be C	17. Father's Name (First, Middle, Las John Fick						18. Mothe Edith		(First, Middle	, Maiden	Sumame)		
Health and tem 27 is m other treum		19a. Informant's Name/Relationship Christina Behnken/Da				ng Address (Perglen				Route Numb 11 Mary		Town, State	∍, Zip C o	ode)
ment of He ent: If item ury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Contro	cify)	Dulai	emetery, crei	osition (Name matory or oth ley Men	her place			ate '05		cation - City o		
Department importent: I eny injury o		21. Signature of Funeral Service Lic	ensee Christin	na L. Hi	Iton 7	eonard	Address Ford	ick, I	hc. Balti	more Ma	rvland	1 21214	4	
ysician		Immediate Cause (Final	N V	h line.	. Do not en	ter the mode	of dying	g, such as	cardiac or	respiratory a	rrest,		In	pproximate terval Between nset and Death
Medical and points it and it and it is an it is	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or	e He	fice of):	ndio	e of dying	g, such as	cardiac or	respiratory <u>a</u>	rrest,		In	terval Between
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ORIGINAL

			_ State	State of Maryland / Dep	ertificate of De	oath	giene 005	01846
			Registrar 1. Decedent's Name (First, Middle, Last)		Timouto of D	2. Date of De		3. Time of Death
	Physici	an	11		Dohain	Month	Day Year	C 1 2 3 4 14
	/Medic		1enes 1 +a 4a. Eacility Name (If not institution, give str	eet and number)	4b. City. Town, or Le	ocation of Death	4c. County of Dea	
	Examin	er	11 -	leines HosptiaL	Baltin	1000		
	Funeral		5. Social Security Number 6. 8ex	7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. 8. Date of Bir	th 9. Bi	thplace (State or Foreign
	Director		346-58-7565 ^{1□}	4 2XF 39 Yrs.	Months Days	Hours Min. July 2	th Year) 9. Bi	linois
	pu ,		Usual Residence of Decedent	10c. City, Town or L				10d. Inside City Limits
	show	-	10a. State 10b. County		ngton, DC			1 ☑ Yes 2 ☐ No
	18a-1	ecto	N/A N/A	11001121			10g. Citizen of What C	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 Ia marked othar than "natural", or Itama 23a or 28a-f show or othar traumatic avant, the Medical Evair are must be untilled at	by Funeral Director	10e. Street and Number 1435 Girard St.	NW #3	10f. Zip Code 20009		USA	ountry :
	deat	ner	11. Marital Status	. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hisp If Yes, specify Cuban.	panic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)	14. Race - Am Black, Whi	
9	after or Its	/Fu	1 ☐ Nøver Married 2 🎛 Married	1 ☐ Yes 2 XNo If Yes, Give		Specify:		ilipino
5-0036	ural',	d b	3 Widowed 4 Divorced	Year or Dates:				
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2121	withir ane. than	Completed	Elementary/Secondary (0-12)		ales		Business	s Keys
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Maryland	2 should be filed within in and Mental Hygiene. I la marked othar than "raumatic avant, Ita Men	To Be	Jose Pena			Lydia Ferre	ria	
lar	2 sho and f la ma auma		19a. Informant's Name/Relationship (Type		,	d Number or Rural Route Numb		
-	1 and 2 Health tam 27		Daniel Dabrieo/	-	O. Box 77			
ore	of H of H if Itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re.		ematory or other place)		20c. Location - City o	
Ē	Pag tment tant: jury o		* 4 ☐ Donation 5 ☐ Other (Specify)	Fairia	x Memoria			
Baltimore	permit. Pages 1 and Department of Heali Important: If Itam 2 any injury or other once.		21. Signature of Funeral Service Licenses		22. Name and Address 9902 Brado	of Facility Fairfax dock Rd. Fair	Memorial rfax, VA	Funeral 22032
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not el cause on each line.	nter the mode of dying,	such as cardiac or respiratory a	rrest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Septic Shock				Onset and Death
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ox (death certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy			23d. Date of de	alivery
ğ	death certific e attending p od for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
0	t the by th	hys	9 □ Unknown ^T	9∐ Unknown				
Э,	w requires that the been signed by the should be detache	by P	Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given	in Part I. 23e. Did	tobacco use contribute	
ord	en sig	ed				1 🗆	Yes 2 No 3 F	robably 4 Dunknown
Records,	aw 1s b	Completed				24a. Was	psy prior to	utopsy findings available completion of cause of
H	Th ate pag	TO.				perfe iy ≤ Yes	ormed? death? 2 □ No 1 □ Ye	
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of Death (Check only	one)	
of V	Physician: this certific ral director,	10	1 ☐ Yes 28 No	spital: Inpatient 2 ER/Outpati		4 Nuising Home 5 Nes		ecify)
ū	fter Ter	on:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?		how injury occurred	
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Division	or Atter after Dirac	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office		wn, State)	13121 710318 740111207,
_	spital		29a. Certifier The Certifying Physic	cian: To the best of my knowledge, dea	ath occurred at the time	, date and place, and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Medicai		er: On the basis of examination and/or and manner stated.				
	To the within To the Comp	Me	29b. Signature and title of certifier)	29c. License		29d. Date signed (Mor	
			4/11/1	ICCINI	RES	-000	JANUARY 1	2,2005
	_2			npleted cause of death (Item 23a) (Type	e, Print)		2.767	
	Ŷ	l de	JONATHAN PICCIN			BALTIMORE, MD	C (C 8 T	
	Sta Regist	ate rar	31. Date filed (Month, Day Year) 6	2005 Regil tar's Signature	Sparker			

J	00403		1- For Unpend Item Registrar	23a, pt.1	Marylar 1	d/Depa er me Ce	CS40 rtifica	nt <u>of</u> H te of L	ealth a Death	nd Me	ntal Hyg	giene Reg. No.	2005	01847
			1. Decedent's Name (First, Middle, La	st)						2	2. Date of Dea	ath Day	/ Year	3. Time of Death
	Physici /Medio		PAUL THOMAS D	OYLE						J	anuary	4 -	_2005	09:45A. M
	Examin		4a. Facility Name (If not institution, given	e street and numi	ber)		4b. Cit	y, Town, or	Location of	f Death		4c.	County of Deatl	
			133 Charles Place	1-				ndian		Od Hee			narles (
	Funeral Director		5. Social Security Number 6. \$ 485-56-2174	5ex 1.2⊠M 2.□F	'. Age <i>(In yr</i> s. 57	Yrs.	Month	er 1 Year Days	Hours 1	Min.	B. Date of Birt (Month, Da) 08/19	y, Year)	9. Birth	nplace (State or Foreigr untry) 17
			Usual Residence of Decedent		<i>J</i> ,						00/19	/ 19	47 IOW	A
	yland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					-		10d. Inside City Limits
	e Ma	ctor	MD CHARLE	S		IND	IAN	HEA	D					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Z	ip Code				10g. Citi	zen of What Co	untry?
	ath w		133 CHARLES P						2064			US		
	hours after death with the Maryland tursi', or Items 23e or 28e-f show at Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Deced	es?	.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Orig n, Mexican,	jin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		 Race - American Black, White 	
36	irs aft	by F	3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 If Yes, Give Year or Dat			1 🗆 Yes	2 No	Specify:				Specify: WH	ITE
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2	within 7 ene. than "n	pie	(Specify only highest gr	College (1-	4or 5+)	life.	DO NOT	use retired,		_				
7	filed within Hygiene. other than	Completed		5+		OWNE	R/	SELF		LOYE			Y CLEA	NING
Maryland	9 G T U	Be	17. Father's Name (First, Middle, Last)							First, Middle,		Surname)	
$\frac{8}{5}$	should be nd Menta i marked umatic ev	٩	CHARLES DOYLE	(Tone Deine)		105 14-10		(0)			E HEN		T	
N N			19a. Informant's Name/Relationship (JEANETTE DOYL)	· · · · · · · · · · · · · · · · · · ·	(G		•	,					r Town, State, 2 IA. 52	, ,
	of Health of Health item 27 i		20a. Method of Disposition	D (110 1111D	20b. F	Place of Dispo	sition (N	ame of	1	Da			cation - City or	
Q E	ages ant of it: If if		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		tate i	semetery, crei KDALE		other place	arder	MS OI/	24/2005	DAV.	ENPORT	ТΔ
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Division	death death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place o	of Injury - At h g, etc. (Special	ome, farm, str fy)			163 2		f. Location (S City or Tow			ral Route Number,
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	To the To the comp	ž	29b. Signature and title of certifier				2	9c. License	number		2		e signed (Month	
			I him his,	nio				OCM	E			Janu	uary 18	2005
			30. Name and address of person who		of death (Iter									
			LING LI,		Otenzia Circa	111 P	enn	Stree	t, Ba	ltimo	re, Ma	ryla	and 2120)1
	Sta Registi		31. Date filed (Month, Day, Year)	2005	Page Solgna	ature /	1034							

			For State Registrar	State of	Marylan		artment tificate				ental Hy	giene Reg. No.	2005	01848
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ł	Examin		4a. Facility Name (If not institution,		ber)				Location of	of Death		4c. (County of Dea	th
			BON SECOUR HOS		. Age (In yrs.	last hirthday)	BAL If Under	TIMC	ORE If Under	24 Hrs.	8. Date of Birt	th.	N/A	thplace (State or Foreign
	Funeral Director		238-68-9520	1 M 2 X F	- Age (III yis. I	60 Yrs.	Months	Days	Hours	Min.	Month, Da	y, Year)	Co	cuntry) RTH CAROLINA
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						********	10d. Inside City Limits
	Many	ţo	MARYLAND N/A			BAI	TIMOR	E						t⊈Yes 2 □ No
	th the or 284 e rol	Director	10e. Street and Number				10f. Zip					10g. Citiz	en of What Co	ountry?
	ath w	rail	2741 EDMONDSON					2122					U.S.A.	
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212	within 72 ene. then "na	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	during mos i)	t of worki	ng			
	a filed within al Hygiene. I othar then ' vent, the Me	Com	10th grade			PRESS	ER						LEANERS	5
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	He He	- 9	20a. Method of Disposition	augitter	20b. P	Place of Dispo					ate		cation - City or	
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Baltimore,	permit. Pages Department of I Important: If ite eny injury or of		21. Signatura Fundral Service L		,,,,,	WI		d Addres	ss of Facilit BROWN	ty COM	YTINUN			
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of V	Physicien: this certific al director,	2	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 🗀 140		ne 5 Resid			ecify)
n		ion:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	9	f Injury 7, Day Year)	28b. Time of Injury		Bc. Injury Work	/at k? Yes 2□		28d. Describe h	now injury	occurred	
Division	Attending r death. ector: After by the fune	ertification;	2 Accident investig	not be	of Injury - At he	ome farm str	M eet factory		169 2	-	28f. Location /	Street and	l Number or R	ural Route Number,
Οİ	after d Direct	ertif	4 ☐ Homicide determi		ig, etc. (Specif		oot, ractory	, 011100			City or Tov	vn, State)		•
	To the Hospitel or Atteni within 24 hours after deat To the Funerel Director: completely filled in by the	dical C	29a. Certifier (Check only one) 1 Certifying 2 Medical I	g Physician: To the Examiner: On the ba and mann	sis of examina	wledge, death	n occurred a vestigation,	at the tim	ne, date an pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	s stated. e to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	4110					number	ŕ			signed (Mont	
1	HI		30. Name and address of person of REGINSTAD	who completed cause	of death (Item	n 23a) (Type,	Print)	long	we w	St	Balter	676	14d 21	202
	Sta		31. Date filed (Month, Day, Year)	32. B	agistrar's Signa									
i.	Regist	rar	JAN 2 6	2005		J. So	selle!							

DHMH 17 Rev 1/2001

	•	For State Registrar	State o	f Maryla	and / Dep <i>Ce</i>	artment			and M	lental Hy	gien Reg. N		05	018	49
Dhyciai	20	1. Decedent's Name (First, Middle, La	st)		_					2. Date of De Month		ay	Year	3. Time of I	Death
Physici /Medio		Susan McCurdy Eng								Januar			005		P M
Examir	ıer	4a. Facility Name (If not institution, giv		mber)				Location o	of Death			c. County			
		3051 Lindsey Cour 5. Social Security Number 6.5		7 Age //g v	rs. last birthday	Ijam		L_Le If Under:	24 Hrs.	8 Date of Ri		Fred			Foreign
Funeral Director			☐ M 203.F	62			Days	Hours	Min.	8. Date of Bi (Month, Do Oct. 1	2 Year	1942	Penr	place (State or intry) 1Sy Ivan:	ia
		Usual Residence of Decedent													
show		10a. State 10b. County	1		City, Town or L									10d. Inside City 1 ☐ Yes	•
Sa-f	ecto	Maryland Frederic	: K	1	jamsvil		2 /				10- 0	Nat 4 S	15-10		220110
with t	Funeral Director	10e. Street and Number 3051 Lindsey Cour	+			10f. Zip	754				-	itizen of V		,	
heath ns 23	era	11. Marital Status	12. Was Dec	edent Ever in	1 U.S. 13.			spanic Orig	gin? (Spe	ecify Yes or Ne Rican, etc.)				ican Indian,	
is 1 and 2 should be filed within 72 hours after death with the Maryland of the alth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Exercitival market hollied at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Amed For 1 Test of Yes, Girl Yes, Girl Yes, Or D	2⊠No ve		If Yes, spec		Specify:		Rican, etc.)		Specify	ck, White,	, etc. hite	
72 hc	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)		(Giv	edent's Usua e kind of wor	k done o	turina most	t of work	ing	16b. I	Kind of B	usiness/îr	idustry	
dithin hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired,) -			_ n		1		
iled v Hygie Ther ti		17. Father's Name (First, Middle, Last	5		Proj	ect_Di	rect		ar's Name	e (First, Middle		eseal			
d be f antal h) Be	Harold W. McCurdy								h Romig		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,0,		
Should Me mark	2	19a. Informant's Name/Relationship (19b. Mai	ing Address	(Street a			al Route Numb		or Town,	State, Zij	p Code)	
nd 2 alth a lattract	H	Fauzia Tirmazi/ F	riend		3051	Lind	sey	Court	, I	amsvil	1e,	Mary	land	21754	
of Hez	- 7	20a. Method of Disposition	70	Ctata	. Place of Disp cemetery, cre	osition (Nam	e of her place	-	-	ary 26,	00- 1		O'1	own, State	
Page Thent ant: H		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		Cı	Montg cemator	omery ium, I	nc.		200)5		rylar			
permit. Pages 1 and 2 Department of Health important: If Item 27 any injury or other tra		21. Signature of Funeral Service lice	ised	₩0068	89 R	2. Name and ockvil	d Address	Inc.	Robe 300 Maj	ert A. West M ryland	Pumpont	phrey 50-28	Fur V Av	neral Ho renue,	ome/
		23a. Part Ent + the dise 17, or com hock or 1 - 1 ailure. List only Immediate Cause (Final	one cause on e	each line.	eath. Do not er	iter the mode	of dying							Approximate Interval Betw Onset and D	eath
Physician /Medical		disease or condition resulting in death)			Heart :	Failur	е					·	5	month	S
Examiner					cular A	cciden	t						2	years	
7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a cons	sequence of):										
be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c												
be exe ician a burial:		resulting in seattly Last	Due to	(or as a cons	sequence of):										
cate to physic the t	dical	•	d												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		oirth 2 □ F nant at time o	etal death 3	□Ectopic pre						23d. Dai Mo	te of deliv	-	ear
s that ned b	by PI	Part II. Other significant conditions	contributing to d	eath but not	resulting in the	underlying ca	ause give	en in Part I.		23e. Did	tobacco	use cont	ribute to t	the cause of de	eath?
quire an sig		Cardiac Arrythmi	a							1 🗆	Yes 2	2 🙀 No	3 Pro	bably 4 □Ur	nknown
aw re	ompieted									24a. Was		24b.	Were auto	opsy findings a empletion of ca	vailable
tending Physician: The lav leath. for: After this certificate has the funeral director, page 2	Com									perf	ormea?		death?	•	
cian: cian: ertific ector,	Be (25. Was case referred to medical examiner?								Check only					
hysic this o	ို	1 ☐ Yes 2 🔀 No			ER/Outpatie					me 5 Res				(y)	
ling F	ion:	27 Manner of Death 1 ⊠Natural 5 □ Pending		of Injury th, Day Year	28b. Time Injury	of 21	Bc. Injury Work	rat ⟨? Yes 2 □ I		28d. Describe	now inji	ury occuri	red		
ttend death ctor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be		of Injury - A	thome farm s			162 2 1		28f. Location	Street a	and Numb	er or Aur	al Route Numb	oer.
ital or A	Certification:	4 Homicide determined	build	ing, etc. (Spe	t home, farm, s ecify)		, 0.1100			City or To					
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Medical Exa	miner: On the b								date ar	nd place,	and due t	o the cause(s)	
To With	N	29b. Signature and title of certifier	10	>	_			number				_		Day, Year)	
101			ed K				5188	9			Jar	nuary	24,	2005	
10.		30. Name and address of person who	completed caus	se of death (I	tem 23a) (Type	, Print)	004	#10 0) n-	01	. 1	Vfo 1	am.d	20050	
Sta	ate	Deborah B. Rost, 31. Date filed (Month, Qay, Year)	11. U., I 32. F	フムムン こ Registrar's Si	gnature	ove K	uau,	1/ I U Z	, KC	CKVIII	e, P	naryl	and	2000U	-
Regist	rar	14N 5 6	2005	10	A.										
DHMH 17 Rev 1/2	2001	Deborah B. Rost, 31. Date filed (Month, Day, Year)			10	STATE OF THE	1			-					
					ORIGIF	JAL.									

DHMH 17 Rev 1/2001

			1 - Stete Amend Item 1	State of Man Ob per fh	vland / Depa 839 1-26	artment of H -05 tas rtificate of L	ealth a D <i>eath</i>	ind Mental H	lygiene Reg. N	200	15	01850
			1. Decedent's Name (First, Middle, Las	1)				2. Date of Month	Death Da	av.	Year	3. Time of Death
	Physicia /Medic		William	Fraz	TER			JANUA	RY 2	-3	2005	11:14 PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		_	40	County o	of Death	
			NORTHWEST	HOSPITAL		RANDI	accs'	TOWN		BAC	TIM	ORE
	Funeral		5. Social Security Number 6. Se	7. Age (//	n yrs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of (Month, Dec.	Birth Day, Year	2	9. Birthpla	ace (State or Foreign
	Director		0200 12 1005	3/M 2LIF	79 Yrs.			Dec.	24,19	925	Mary	land
50	\$ 050		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation					10	d. Inside City Limits
200	sho sho	2	MD Balti									1 □Yes ¾ No
4	28a-1	ect	10e. Street and Number	7-13-00-5	Owings	MIIIS 10f. Zip Code			10g Ci	itizen of W	hat Count	
with 1	B Or	급		. Paral		21117	L			LSA		.,,.
5-0036	18 23	Funeral Director	10 Morriswa	12. Was Decedent Eve	er in U.S. 13.	- 1 1 1	spanic Orio	in? (Specify Yes or			- America	n Indian.
ter d	The Tar	ä	1 Never Married 2 Married	Armed Forces? XIXIYes 2 ☐ No			n, Mexican,	jin? (Specify Yes or , Puerto Rican, etc.)			k, White, e	
5-0036	0,0	ρ	3 Widowed 4 Divorced	Tryes, Give Year or Dates:	WWII	1 ☐ Yes XX No	Specify:			Specify:	Whi	te
9	atur	Completed	15. Decedent's Ed			dent's Usual Occupa		of working	16b. F	Kind of Bus	siness/Indi	ustry
215	. E	ple	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retired,)	or working				
2	/gien	Con	12			Carpente						tion
pu	and Mental Hygiene is marked other than "natural", or Items aumatic svent, the Medical Examinar m	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Mide		n Sumame	9)	
Maryland	Men	은	William L. F					rrie Gil	- 15			
lar	is m		19a. Informant's Name/Relationship (7					r or Rural Route Nui	-			
7, 7	Health tem 27 i		Elizabeth Ann Fr		20b. Place of Dispo		ay R	d. Owing		LIS,		
Ore	to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic svent. Its Medical Examinar must be natilied at		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other place					•	
tim	tant: jury		`4 ☐ Donation 5☐ Other (Specify					/28/05				ills, MD
Baltimore,	populus reges far Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	×69				Eckhardt				
	7 C) = 48 OI		Miller !							gs M		,MD21117
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	e death. Do not en	ter the mode of dying	g, such as o	cardiac or respirator	arrest,			Approximate Interval Between Onset and Death
3/	hysician		Immediate Cause (Final disease or condition resulting in death)	a CORO	NARY 1	ARTERY	DUSE	ASE				
	/Medical xaminer		rosaning in ocaliny	Due to (or as a c	consequence of):							
		Į.	Sequentially list conditions,	b. Due to (or as a c	onSequence of).							
1/19	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
V 15	and al-tra	хаг	that initiated events resulting in death) Last	Due to (or as a c	consequence of):							
8760	Siciar			d							- 11	
x 687	attending physician and for use as the burial-transit	Physiclan/Medical		u								
	nding use a	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75				23d. Date	of deliver	у
B.	a atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 (4 ☐ Pregnant at tir		⊒Ectopic pregnancy □ Other <i>(specify)</i>			_	Mon	th [Day Year
0 2	che t	hys	9 Unknown	9□ Unknown					-			
Q. 3	igned be det	by P	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	inderlying cause give	en in Part I.	23e. D	d tobacco	use contri	bute to the	cause of death?
ords,	n sig	be						1	⊒Yes 2	2 □ No	3 🗌 Proba	bly 4 ⊟Onknown
O S	0 5	olet						24a. W		24b. W	/ere autop	sy findings available
Re	ate has page 2 s	Completed							itopsy orformed? s 2 ☑ No	/ de	eath?	pletion of cause of
	certificate	0	25. Was case referred to medical				26. Place	of Death (Check on		0		
	is certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nui	rsing Home 5 🗆 R	esidence	6 □Othe	r (Specify)	
			27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	of 28c. Injury		28d. Descrit	e how inju	ury occurre	ed .	
ior		atlo	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation				Yes 2 1	No				
	er de recto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st	reet, factory, office		28f. Locatio City or	n (Street a Town, Stat	nd Numbe te)	or Or Rural	Route Number,
	al Dir	Certification:										
	within 24 hours after death To the Funeral Director: completely filled in by the	edical		ysician: To the best of r								
2	within 24 To the Forcemplete		one)	and manner state								
F	To Too	Σ	29b. Signature and title of conffier			29c. License		2	290. Da	ate signed		
					M-1	v. Ds	772		JA	NVAR	12	3 2005
	16		30. Name and address of person who							123		
	10		LEONARD RICHARD SON 31. Date filed (Month, Day, Year)	11. P. 5401 0	Signature 3	ILOAD RA	NPACES	JOWN MD	21	1>5		
	Sta Regist		JAN 2	6 2005	Colores D	Mouse						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			1- State of Maryl		artment of H <i>tificate of L</i>			ienę UU5	01851
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		Richard John Fisher				Jan 2	24 2005	6:05 p ^M
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death	
			948 Boiling Springs Ct	and the said to the said of th	Millers If Under 1 Year	Ville If Under 24 Hrs.	O. Data of Blints	Anne Arund	
H	Funeral Director		219-40-1350 X M 2 F	yrs. last birthday) 60 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 3/22/19	Year) 9. Birth Cou Mary	place (State or Foreign ntry) land
	and and		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	tor	MD Anne Arundel	Millers	ville				1 ☐ Yes 2 ☐ No
	h the	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
	23a c	ai D	948 Boiling Springs Ct.		21108		US	SA	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "netural", or items 23e or 28e-f show or other traumetic event, the Macing Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married It Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	
21215-0036	within 72 ho ene. than "netur re Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	DO NOT use retired	luring most of worki	ng 1	6b. Kind of Business/Ir	
	filed v Hygie other t		10 17. Father's Name (First, Middle, Last)	Driv	ver	18. Mother's Name	(First, Middle, N	Dry Cleani	ng
Maryland	ould be Mental I	To Be	unknown				Brown	•	
ary	2 should and Men is marka aumetic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a			City or Town, State, Zi	Code)
	is 1 and 2 of Health a itam 27 is othar trai	1 3	Mary Ann Fisher / wife					sville MD	
altimore,	jes 1 of He if itan or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	θ)		20c. Location · City or T	
ţi	Pages tment of tant: If it		`4 □ Donation 5 □ Other (Specify)	Metro Cre		1/28/	2005 C	Catonsville	, MD
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Juneral Service Licensee	Ba 4	!. Name and Addres arranco & 95 Ritchi	Sons, P. e Hwy Sev	A. Sever erna Par	na Park Fu k MD 21146	neral Home
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical	i i	Immediate Cause (Final disease or condition resulting in death)	~	ladder co	incer			SMOS
	Examiner		Due to (or as a cor	nsequence of);					
Į,		jer	Sequentially list conditions, if any, leading to immediate cause Field of anying Cause (Disease or injury	isequence of):					
1	cuted	Examine	that initiated events						
oʻ	e exec ien ar urial-tu		resulting in death) Last Due to (or as a cor	sequence of):					
68760,	ficate be executed physicien and is the burial-transit	edicai	d					<u> </u>	
. Box	ath certif ttending or use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of properties of the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
P.0	that the de ned by the a detached f	Physici	9 Unknown				an Didas		to a second depth 2
	sigr sigr d be	d by	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.		acco use contribute to to s	
of Vital Records,	The ate h page	Complete					24a. Was ar autopsy perform 1 Yes 2	prior to co ned? death?	opsy findings available impletion of cause of 2 No
/ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Cth	26. Place of Death	(Check only one	9)	
of \	Phys this al di	- T	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		4 Nursing Ho	ne Reside 28d. Describe ho	nce 6 Other (Speci	(y)
		tion	1 Natural 5 Pending (Month, Day Yea		Worl		ESG. DOSCRIDO NO	w injury socialise	
Division	at or Attanding safter death. I Diractor: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S)		eet, factory, office		28f. Location (Str. City or Town,	reet and Number or Rur , State)	al Route Number,
	To tha Hospital or Atti within 24 hours after de To tha Funaral Diracto completely filled in by th	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my and manner stated.						
)	To the To the comp	Me	29b. Signature and title of certifier Allowith W		29c. License	9 83 8	29	ed. Date signed (Month,	Day, Year) .005 Ud, 2140]
	10		30. Name and address of person who completed cause of death STURY F. SCIOULCU, U		50 Best	gate Rd	Ani	rapolis, a	ud, 21401
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature &	anti				

			1 - State Registrar	State of Ma		artment of I			Reg. No. 2 (005 0185	2
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Mildred Charlotta	a Feist				2. Date of Dea January	/ 2 ^a y, 20	3. Time of Death 5:30PM M	
	Examin		4a. Facility Name (If not institution, give s 9028 Hines Road	treet and number)		4b. City, Town, Baltimo		f Death	Balt:	y of Death I MOME	
	Funeral Director			M 2 X F 7. Age	(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days		8. Date of Birt Min. July 1	, 1 912	9. Birthplace (State or Foreign Mary Tand	
	Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	e	10c. City, Town or Lo					10d. Inside City Limits 1 □ Yes 2 🏋 No	
	3a or 28	I Dire	10e. Street and Number 9028 Hines Road			10f. Zip Code 2123	4		10g. Citizen of U.S.	What Country? • A •	
036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-f ehow the Modical Executiver: ust be rediffed at	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E- Armed Forces? 1Yes 2XNo If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut		gin? (Specify Yes or No., Puerto Rican, etc.)	14. Rad Bla Specii	ce - American Indian, ack, White, etc. fy: White	Ī
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f ehow eny injury or other traumatic event, the Modical Executives: ust be redifficated once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation completed) College (1-4or 5+	(Give	dent's Usual Occu kind of work done DO NOT use retire Hair St	during most ad)	of working		Business/Industry Employed	
Maryland	uld be filed Mental Hyg Irked othe	To Be C	17. Father's Name (First, Middle, Last) Charles H. Arnold,	Jŕ.			7.1	r's Name <i>(First, Middl</i> e, rginia T. W			
	nd 2 sho alth and 1 27 is me ir traume		19a. Informant's Name/Relationship (Type Mr. Ernest L. Fei	•		ng Address (Stree Hines F		or or Rural Route Numbe Baltimore,	-		
nore,	ages 1 and of Heam It of Heam		20a. Method of Disposition 1	emoval from State	20b. Place of Dispo			Date		- City or Town, State	
Baltimore,	permit. Po Departme Important eny injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of an yal Servic licens	THE THE	22	2. Name and Addr	ess of Facility		J. Ruck	, Inc.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused to cause on each line	he death. Do not ent	er the mode of dy	ing, such as	cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):	X/ (0	دوی ۱۸	7		- 2 years	
, ₀ ,	icate be executed physician and the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760,	tificate b ng physic as the bi	ledical	d	l							_
P.O. Box	that the death certifics ed by the attending pl detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			ate of delivery onth Day Year	
ecords, P.	es ign	d by	Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	tere"	ntribute to the cause of death? 3 Probably 4 Unknown	
α	The ate ha	Complete						24a. Was autop perto 1 Yes	rmed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
f Vital	/sicien: s certific director,	To Be	25. Was case reterred to medical examiner? 1 Yes No	ospital:	t 2 ER/Outpatier	nt 3 DOA	No man	of Death (Check only o		her (Specify)	
ion of	ing After une	ertification: 7	27. Manner of Death Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	W	ury at ork? ∐Yes 2 ∐1	28d. Describe h	now injury occur	rred	
Division	s after death s after death al Director;	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, sti . (Specify)	reet, factory, office		28f. Location (S City or Tow		ber or Rural Route Number,	
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical (examination and/or in			d place, and due to the th occurred at the time,		nanner as stated. , and due to the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	110 N	\sim		ise number	. (4	ed (Month, Day, Year)	
	6		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print) 7524 R	elain	Rd Ralt	5m-10	MD 7/23/-	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 6 2	32. Regiona 2005	r's Signature	Sporte	1-(//		- r - cary &	MD 21236	_

				State of Marylar						01050
			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	01853
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	3. Time of Death
	/Medic	al	Anna M. Fisher 4a. Facility Name (If not institution, give s	street and number)		4h City Town	or Location of Death	Januar	y 23, 2005 4c. County of Deat	12:50 PM
	Examin	er	Annapolitan Assisted I			Annapo		•	Anne Aru	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da July 2		hplace (State or Foreign
	Director		577-05-7573	M 2気F 92	Yrs.	World's Days	Tiodis Iviii.	July 2	9, 1912 Mar	yland
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	e-f sh	ctor	Maryland Anne Aru	ndel Ar	napoli	.S				1 ☐ Yes 21 No
	ith the	Dire	10e. Street and Number	_		10f. Zip Code			10g. Citizen of What Co	
	s 23e	eral	84 Old Mill Bottom	Koad 12. Was Decedent Ever in U	10 12	21401	diamania Origina /Sr		United Stat	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If it is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinar must be naillised at	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cub	Hispanic Origin? (S) an, Mexican, Puerto Specify:	Rican, etc.)	C	
21215-0036	2 hour	Completed by	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	oation		16b. Kind of Business/	
215	thin 72 9. 8n "na Medi	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word)	king	National I	
2	filed wil Hygien othar th ent, the	Соп	12		Secr	etary	T	(of Heal	
Maryland	2 should be filed within and Mental Hygiene. is marked othar than aumatic event, the Ma	Be	17. Father's Name (First, Middle, Last) John Martin Fanon				Annie Mc		, Maiden Sumame)	
2	should and Men marke umatic	은	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Maili	na Address (Street			er, City or Town, State, 2	Zip Code)
Z	nd 2 salth ar 27 is rr trau		John Fisher/ Son						Maryland 21	
ore,	ss 1 a of Hez litam r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	20b.	Place of Dispo	osition (Name of matory or other pla Mary s		Date	20c. Location - City or Rockville,	
ij	Pagement anti-		* 4 ☐ Donation 5 ☐ Other (Specify)	Ce	metery		200	5	Marylan	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is eny injury or other tra <u>once.</u>		21. Signature of Funeral Service Doenfe	M00689	R	ockville	, Inc. 30	0 West 1	Pumphrey F Montsomery 20850-2805	uneral Home/ Avenue,
100			23 / Part 1 Intel the disease, or compli- shoot. If he at allure. List only or	cations trint one ed the dea	th. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Imm diate se (Final diseas or condition	Emphysema						Onset and Death
	/Medical Examiner	H	resulting in death)	Due to (or as a consec						
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec					-	
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classe of Injury that initiated events							
oʻ	e be executed sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ate be	dlcal		1						
89 хо	death certificate b rattending physic d for use as the b	/Med	IF FEMALE:	3c. If yes, outcome of pregn	ancy				23d. Date of del	
.O. Bo	The law requires that the death certificate be executed the law speed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	Ectopic pregnanc Other (specify)	у		Month Month	Day Year
ط	res that the d igned by the be detached		Part II, Other significant conditions con	ntributing to death but not re-	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	quires n sign ald be	d b	Dementia					1 🗆 '	Yes 2⊠No 3∏Pr	obably 4 Unknown
000	aw requir s been si 2 should I	olete						24a. Was	an 24b. Were au	topsy findings available completion of cause of
l Re		Completed by						autor perfo	irmed? death?	2 No
/ita	yaician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea			Vaciated
of Vital	Phya this	- T	1 ☐ Yes 2 ②XNo 27. Manner of Death	fospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	IL SELECT			dence 6 🖾 Other (Spec	Living
O		tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No	Edd. Describe	now injury occurred	
Division	for Attendated of the death Director:	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, st	reet, factory, office			Street and Number or Ru	ıral Route Number,
Ö	tal or Att s after d el Direct ed in by	Certification:	4 ☐ Homicide determined	building, etc. (Speci	·y)			City or To	wri, State)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical		sicien: To the best of my kn ner: On the basis of examinand manner stated.						
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licens		1	29d. Date signed (Monti	
) ,	1.0		John lu			D40	0519		January 25,	2005
C	711		30. Name and address of person who co				C	0 5:	No. 0111	
	<i>y</i> '	10	Mirza M. Nusairee 31. Date filed (Month, Day, Year)	32. Registrar's Sign		Circle,	Suite #1	, Croft	on, MD 21114	+
	Sta Registi		JAN 2 6 21		2	1				

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	1	State	ate of Maryland /		ent of He			2005	01854	
Physicia	1	1. Decedent's Name (First, Middle, Last)			GOR		2. Date of Death Month	Day Year	3. Time of Death	
/Medica Examine Funeral Director	ľ	4a. Facility Name (If not institution, give street	05 PITAL 7. Age (In yrs. last)	4b.	City, Town, or Lo	S TO WW If Under 24 Hrs.	8. Date of Birth	4c. County of Dea BALTIM (eer) 9. Bin Co	h	
y Mar ylatin Z 1 Z 1 2-000 and 2 should be filed within 72 hours a salth and Mental Hygiene. n 27 is marked other then "naturel", c er treumatic event, it a Medicales.	to be completed by runeral Director	1 Never Married XX Married 1 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade continuous)	Ow: Vas Decedent Ever in U.S. med Forces? Yes, Give ear or Dates: npleted) Print) Spouse 20b. Place	13. Was E If Yes, 1 Yes, 1 Yes, (Give kind of life. DO No. HO	ills Exip Code 21117 Decedent of Hisp specify Cuban, les XX No Usual Occupation for work done durant user etired) memake iress (Street and mere R (Name of	anic Origin? (Spe Mexican, Puerto Specify: on ing most of works at Mother's Name Agnes	acity Yes or No-Rican, etc.) Ing Ing Ing Ing Moore Al Route Number, to ings Mi	g. Citizen of What Co U.S.A. 14. Race - Ame Black, Whit Specify: Wh. Sb. Kind of Business Own Hom	10d. Inside City Limits 1 □ Yes X²X No untry? incan Indian, e, etc. ite Industry ie iip Code) 21117	
Physician /Medical Examiner B panial-transit		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	ns that caused the death. Duse on each line. BREAS Due to (or as a consequence) Due to (or as a consequence)	1160 To not enter the Toe of):	5 Reist	terstow such as cardiac o	n Rd.Ow	ings MI1	apel P.A. Is, MD21117 Approximate Interval Between Onset and Death	
death certific	riiysiciali/medi	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal dea □Pregnant at time of death □Unknown		nic pregnancy r (specify)			23d. Date of del Month	very Day Year	
25 8 6	Completed by F	Part II, Differ significant conditions contributing to death but not resulting in the underlying cause given in Part I.						2 No 3 Pr	Were autopsy findings available prior to completion of cause of death?	
n OI VIICA ng Physicien. tter this certific ineral director.	o De	2 Accident investigation	1 Minpatient 2 LIERV	Outpatient 3[D. Time of Injury M farm, street, fa	DOA Other: 28c. Injury a Work? 1 Ye	4 ☐ Nursing Hort t : s 2 ☐ No	The 5 Resident	ce 6 Other (Specinjury occurred	ify)	
he Hospi in 24 hou he Funer pletely fill	edical	(Check only 2 Medicel Examiner:	n: To the best of my knowled On the basis of examination and manifer stated.		ation, in my opin	ion, death occurr	ed at the time, date	and place, and due	to the cause(s)	
To To Com		29b. Signature and fills of officer 30. Name and address of person who comple	M · F		29c. License n	722	2	ANUARY 2	1 2005	
State Registra	9	31. Date filed (Month, Day, Year) IAN 2 6 200	M.P.: S401 32. Registrar's Signature	OLD CO	URT RO	AD RAN	PALLSTON	IN MO Z	1133	

DHMH 17 Rev 1/2001

Registrar

The district and property The district and property						partment of Health and Mertificate of Death		ene 2005	01856
THE PROPERTY WHITE TO THE PROPERTY WHITE TO					Charles William Hughes, Jr.	J	Month		
Temporary Temp		1		ner	ST AGNES HEALTHYARE	4b. City, Town, or Location of Death BALTIMORE		4c. County of De	ath
Section Control Cont			Director		216–32–1983 11XM 2□F 69 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Aug 27, 1	9. Bi	rthplace (State or Foreign Sountry) aryland
Section Control Cont			e Maryland le-f ehow	ctor					10d. Inside City Limits 1X Yes 2 □ No
Section Control Cont			ath with th	ral Dire	1820 Spence Street Apt. 202		-		•
Section Control Cont		920	urs after des el', or Items	by	1 Never Married 2 Married 1 Yes 2 No		cify Yes or No- Rican, etc.)	Black, Wh	ite, etc.
Section Control Cont		1215-0	vithin 72 hol ne. h an "netur e Medical	npleted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of workir DO NOT use retired)	ng		
Section Control Cont		nd 21	al Hygier I other tl vent, th		17. Father's Name (First, Middle, Last)	-			City
Section Control Cont		ıryla	should b nd Ment marked imatic e	To	The same of the sa			lity or Town State	Zin Code)
232 Part Enter the disease, or complications of the date of the date of the date of the date of the date of the disease, or complication of the date o			an feal m 2		William Hughes / Brother 645 20a. Method of Disposition 20b. Place of Disp	Chester River Bead	ch Rd, Gr	asonville	e, MD 21638
232 Part Enter the disease, or complications of the date of the date of the date of the date of the date of the disease, or complication of the date o		3altim	emit. Pag epartment nportent: It ny injury o			Crematory 1/24/	/2005 Ba	ltimore,	Maryland Inc
Season Part Condition			70 F 9 0		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	<u>410/W11Kens Avenue</u>	≥. Baltim	ore. Mary	Approximate Interval Between
### STATE STATE ### STATE STATE ### STATE			/Medical		disease or condition resulting in death) a				Unknown
State Stat	P	_	uted d ansit	miner	if any, leading to immediate Due to (or as a consequence of):	2446 000			
FFEMALE: 236. If yes, outcome of pregnancy 1 Uve birth 2 Fest death 3 Ectopic pregnancy 1 Uve birth 2 Fest death 2 Uve birth 2%	8760,	ate hy	dical Exa	resulting in death) Last Due to (or as a consequence of): d.	District District				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	M SE	Box 6	the death certific	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 (4 Pregnant at itime of death 5 (•
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	ARLI		quires that an signed t uld be deta	ed by PI		inderlying cause given in Part I.			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	3	Reco	The law reate has bee	omplet	ACUTE RENAL FAILURE		autopsy performed	rior to death?	completion of cause of
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 7 WAL TARANILA 22 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature 32b.	无	Vita	sicien: certific rector,	Be	25. Was case referred to medical examiner?		(Check only one)		
MEDICAL INESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THINALITY RANILLA 900 CATDIN AVE BALTIM OF MANYLM. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	HVG	sion of	ending Physath. or: After this	ation; T	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at 28 Work?			city)
MEDICAL INESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THINALITY RANILLA 900 CATDIN AVE BALTIM OF MANYLM. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Divis	oital or Att urs after de rel Directu lled in by t	Certific	4 Homicide determined building, etc. (Specify)		City or Town, St	tate)	
MEDICAL INESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THINALITY RANILLA 900 CATDIN AVE BALTIM OF MANYLM. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			the Hosp hin 24 hot the Fune npletely fi	Medical	one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	d at the time, date a	and place, and due	to the cause(s)
State 31. Date filed (Month, Day, Year) 22. Registrar's Signature				~	MEDICAL MESIDENT	P18620	JAN	YUARY Z	2, 2005
JAN & O (UU) ANAMA AT ADMINI					31. Date filed (Month, Day, Year) JAN 2 6 2005		AVE E	ALTIMO,	EE MANYLMI

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month HICKS 2Ó ANTHONY 2005 7:25 A M January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 701 Carlough Street Prince George's Landover 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F Director 577-54-8745 64 1940 Maryland November Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinal mark to exciting at Director 1 ☑ Yes 2 ☐ No Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Carlough Street 20785 Completed by Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ⊠Yes 2 No Army
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Hicks Dorothy Howard ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jewell Hicks/Wife 701 Carlough Street Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 2/1/05 Cheltenham, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral S vice L cens e No. 23 Part. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or head failure. List only one cause on each line. 7474 Landover Road Landover, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Abdominal Aortic Aneurysm Sequentially list conditions sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): The law requires that the death certificate be executed burial-transit Congestive Heart Failure and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 Completed 1 Tes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2⊠ No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No after death 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Sienature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24052 January 25, 2005 ess of person who completed cause of death (Item 23a) (Type, Print) John McKnight M.D. 106 Irving Street N. W Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar porte

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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,	Baltin	
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Division of Vital Records, P.O. Box 68760,		Ś
	n of Vital Records, P.O. Box 6	I the society of the

				ack Indelible Ink. Ensu / Department of Health a			_	
		1 - For State Registrar		Certificate of Death		Reg. No	2005	01858
Physici	an	1. Decedent's Name (First, Middle, Last)	FRANCE	4/11/1	2. Date of Month	Death Da	ıy Year	3. Time of Death
/Medio	cal	4a. Facility Name (If not institution, give s	3 KHNUS	4b. City, Town, or Location of	JANU		2\ 2005 c. County of Death	4:04 PM
Exami	ier	GOOD SAMARITAN	HOSPITAL.	BALTIMORE		100	. County or Dougr	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		4 Hrs. 8. Date of Min. (Month	Birth Day, Year	9. Birth Cou	place (State or Foreign
Director		Usual Residence of Decedent	85	113.	1.	14.1	121 MA	HKYLHND
arylan show	_	10a. State 10b. County	4	of wn or Location				10d. Inside City Limits
the M	recto	10e. Street and Number		PACTIMORE 101. Zip Code		100 Ci	tizen of What Cou	1 M Yes 2 No
th with 23a or	al Di	1529 NORTH 1	BOURNE ROA		39	rog. Or	U.S.	A.
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. I the strain and Mental Hygiene is the strain and st	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Orig	in? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Ameri Black, White,	
urs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 V No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:				ACK
72 hou natura	eted	15. Decedent's Educ (Specify only highest grade	cation 16	6a. Decedent's Usual Occupation (Give kind of work done during most	of working	16b. K	(ind of Business/Ir	ndustry
within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) DOMESTI			DRIVA	tE.
should be filed within to Mental Hygiene. marked othar than matic evant,		17. Father's Name (First, Middle, Last)			's Name (First, Mid	ldle, Maider		
uld be Mental irked o	To Be	HENRY	MELLO	N	ELLIE	IN	ATKIN.	S
2 should and Men Is marke	'	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street and Number	2. 0.	- 11	or Town, State, Zij	Code)
1 and Health am 27 thar tr		CAKLITA KEARNE 20a. MetWood of Disposition	24 DAVGHTER	of Disposition (Name of	KNE KOA	-	CATIMORE OCATION - City or To	Mb 21239
ages ant of l it: If it		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		ptery, crematory or other place)				
permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	10H. C	22. N me and Address of Ficility	VAVGHN	C G1	CENE TU	MARYLAND NERM HOME
permi Depa Impo any ir) lague	Shere	4105 YORK ROA	D BAUTI	MORE	, MARYL	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Decause on each line.	o not enter the mode of dying, such as o	ardiac or respirator	y arrest,	1	Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	SERSIS.					Chisat and Death
Examiner			Due to (or as a consequence	ce of):				
D H	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
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e be ex sician surial	7							
rtificate ng phy as the	Physician/Medic							
ath ceu ttendir or use	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea				23d. Date of delive	•
he dea	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		_	MONIT	Day Year
s that the ned by a detail	by Ph	Part II. Other significant conditions con	ributing to death but not resulting	g in the underlying cause given in Part I.	23e. D	id tobacco u	use contribute to the	he cause of death?
equires en sig		Acute Reval	Failur		1	☐Yes 2	□No 3□Prob	pably 4 Nonknown
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g Phy er this	\vdash	27. Manner of Death		D. Time of 28c. Injury at	ing Home 5 R			y)
andin sath. or: Aft he fur	atlo	1 Natural 5 Pending investigation	(Month, Day 19ar)	Injury Work? M 1 Tes 2 N	0			
or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Locatio City or	n <i>(Street an</i> Town, State	d Number or Rura)	l Route Number,
spital ours a neral [29a. Certifier Certifying Phys	ician: To the best of my knowled	ige, death occurred at the time, date and	place, and due to t	he cause/s/	and manner as el	Pater
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the l	Medical	(Check only 2 Medical Examin	er: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death	occurred at the tim	ie, date and	place, and due to	the cause(s)
To the comp	M	29b. Signature and title of certifier	4	29c. License number			te signed (Month,	Day, Year)
10/		I dama dan	Nba.	les 000		JANU	15 MAG	, 2005.
7/10		30. Name and address of person who cor	npleted cause of death (Item 23a		TIMARE	MA		9
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		OTT TORE	1-(12	2123	
Registr	ar	JAN 2	6 2003 Bloom	H. Conster				

			1 - For State Registrar	State of Marylan		artment of H		nd Mental H		/11115	018	350
			Decedent's Name (First, Middle, Last))		timouto or E	30417	2. Date of [3. Time o	f Death
Н	Physici		Rosetta Moore H	Janu.			ry 12	2, 2005				
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of C			. County of De		
			3918 Chesterwood	Drive		Silver	Spring	3	N	fontgome	ery	
	Funeral		5. Social Security Number 6. Sec	IM aKIE		If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Year	9. Bi	rthplace (State (or Foreign
	Director		255-28-1818 Usual Residence of Decedent	104	Yrs.			Oct.	16, 1	1901 No	cth Caro	olina
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside C	ity Limits
	Many Fish	to	Maryland Montgome	ry Sil	ver Sp	ring					1 🗆 Yes	2 ∑ No
	h the	Director	10e. Street and Number	- 1-		10f. Zip Code			10g. Ci	itizen of What C	Country?	
	238 c		3918 Chesterwood D	rive		20906			U.	S.A.		
(0	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Evaninal must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 1 No	1	Was Decedent of Hi f Yes, specify Cubar	spanic Origin n, Mexican, P	n? (Specify Yes or Note:) Puerto Rican, etc.)	No-	14. Race - Am Black, Wh	erican Indian, ite, etc.	
Maryland 21215-0036	hours a	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Specify:			Specify: B1		
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7	iene. than	duo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemaker)wn Home	<u> </u>	
D	filed Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd	le, Maider	n Sumame)		
lar	uld be Menta rked tic ev	To B	Hazikiah Moore				Mary	Martha 1	Moore	2		
ar	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a	nd Number o	or Rural Route Num	ber, City	or Town, State,	Zip Code)	
	Health Health tem 27 other tre		·	Granddaughter		The second second	od Dr.		Spri	ng, MD	20906	
Ore	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R		lace of Dispos emetery, cren	sition (Name of natory or other place	9)	Date	20c. L	ocation - City o	r Town, State	
altimore,	t. Pa rtmen rtent: njury		'4 □Donation 5 □ Other (Specify)			of Memory		-17-05	Blo	unts Cr	eek, NC	
Ba	permit. Pages Department of Importent: If II any injury or o		21. Signature / Funeral Service Licen	Description		Name and Addres Whitfield 312 W. Ma		tley Fundather Kin	eral ng Jr	Home Dr.,	Washing	ton,
	Physician		23a. Part1. Enter the disease, or complishock, br heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death	i. Do not ente	er the mode of dying	, such as car	rdiac or respiratory	arrest,		Approximat Interval Bet Onset and I	ween
į,	/Medical Examiner		resulting in death)	Due to (or as a consequence of the consequence of t	uence of):	10 40	to and	1 : 200				
		er	Sequentially list conditions,	Due to (or as a sonsage		2 /W.	. 0 110 0	, 3				
	uted d ansit	Examin	Sequentially list conditions, if any, is aurig to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0/01	29	2						
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9	ing ph	a)	IF FEMALE:									
Box.	The law requires that the death certific tle has been signed by the attending p age 2 should be detached for use as	sician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month		Year
о. О	at the ded by the a	Physi	9 Unknown									
Records,	w requires that been signed k should be det	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	nderlying cause give	n in Part I.			_	o the cause of d robably 4 🗀	
000	s bee	Completed						24a. Wa		24b. Were a	utopsy findings	available
Ĭ	The lav	шо						— auto per 1 □ Yes	opsy formed? 2 🔀 No	prior to completion of cause of death?		
Vital		BeC	25. Was case referred to medical				26. Place of	Death (Check only		1010	2 2 1 1 1 1 1	
0	hysic his ce I direk	70	examiner? 1 Tes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 □ DOA Othe	r: 4 🗆 Nursir	ng Home 5 🔀 Res	sidence	6 ☐Other (Spe	ecify)	
0	ding Pt	on:	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how inju	ry occurred		
<u>s</u>	tendi death. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				es 2 🗆 No					
Division	after c	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office			(Street ar own, State		ural Route Num	ber,
	To the Hospital or Attending Physician: whith 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier 1 \(\sumetextit{\subseteq}\) Certifying Phys (Check only one) 2 \(\subseteq\) Medical Examir	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	occurred at the time estigation, in my op	e, date and pi inion, death o	lace, and due to the	e cause(s)) and manner a: d place, and due	s stated. e to the cause(s))
	o the	Me	COL CITY OF THE COLUMN	A .		29c. License	number		29d. Da	te signed (Mon	th, Day, Year)	
	L>F0		* * m. 3 /	olella		Doog	599	21		uary 13		
	.0		30. Name and ddress of person who co	mpleted cause of death (Item	23a) (Type. F		-	01	Jan	-uy 1J	, 2003	
				odella, m	D	6005 La	andove	r Rd. # 3	Che	verly,	MD 2078	5
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2	32. Registrar's Signat	ture &	Sporte						

as the burial-transit esn

the attending physician and signed by I After

or Attanding Physician:

within 24 hours after death To the Funeral Director:

in by 1

by

Be Completed

Certification: To

cal

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

in the past 12 months?

IF FEMALE:

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 DEctopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

MID

24a. Was an autopsy performed? 1X Yes 2 □ No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No

3 Probably 4 ∆Unknown

25. Was case referred to medical examiner?
1 X Yes 2 No

determined

hi,

28a. Date of Injury 5 Pending investigation 6 Could not be

28b. Time of Found 1-24-05 Found At 1:40 A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 28c. injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred unk

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 606 Severn Ave. Rosedale, Maryland

Found At Residence

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

O.C.M.E.

29d. Date signed (Month, Day, Year) January 24, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar



DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 ANDREW ROBERT HAGEN JANUARY 23, 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8502 DAYTONA ROAD ROSEDALE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-2-1924 **Funeral** 9. Birthplace (State or Foreign 1**∑**M 2□F 80 Director 219-18-3103 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. sort Heatth and Z7 Is marked other than "naturel", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location rel', or Items 23a or 28a-f show Examiner is ust be notified at 10d. Inside City Limits MD Director BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8502 DAYTONA ROAD U.S.A. Completed by Funeral 21237 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPARROWS POINT 12 MECHANICAL 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ANDREW HAGEN DORA R. (BLANEY) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY HAGEN / WIFE 8502 DAYTONA RD.ROSEDALE, MD.21237 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. HOLLY HILL CEMETERY 1-27-2005 BALTIMORE, MD. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MARYLAND 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a gunsequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit n signed by the attending physician and lid be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably been should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Certification; To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 Tes 2 No 2 Accident the 6 ☐ Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASTERN BLVD. WASERM. 709. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 6 2005 Registrar

			1 - For State Registrar	State	of Maryla		artment of H		and M		giene ()	05	01862
			Decedent's Name (First, Middle	le, Last)						2. Date of Dea			3. Time of Death
	Physic		Norma J	Jean H	elms					January	Day 1 24, 2	Year	5:35 P M
	/Medi Examir		4a. Facility Name (If not institution				4b. City, Town, or	r Location o	of Death	nai inat ?		ty of Death	
	LXamii	iei	628 Lake Drive		,		Towson					imore	
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under a	24 Hrs.	8. Date of Birtl			
	Director		218-26-7081	1□M 2 X)F	78	Vra	Months Days	Hours	Min.	(Month, Da) Sept. 5	, Year)		place (State or Foreign Intry)
	D		Usual Residence of Decedent					1		sept. :	1, 1720	1,15	ryland
	ylan Now		10a. State 10b. County		10c.	City, Town or Lo	ecation						10d. Inside City Limits
	Ma S-6	ţċ	MD Balti	.more		Towson						İ	1 ☐ Yes 2 🛣 No
	r 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?
	h wit	<u>=</u>	628 Lake Drive	1			21286-	7309			USA		
	ф	Funeral	11. Marital Status	12. Was De	cedent Ever in	1 U.S. 13.	Was Decedent of Hi f Yes, specify Cuba		gin? (Spe	cify Yes or No-	14. Ra		can Indian,
9	or Ite	T.	1 Never Married 2 Mar	ned 1 Yes	21 No		_		, Puerto	Hican, etc.)	Bla	ack, White,	
8	rei',	by	3 Widowed 4 ☐ Divorced	If Yes, (Year or	aive		1 □ Yes 2 □ No	Specify:			Spec	ify: L	hite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Heme 23a or 28e-f show ont, the Madical Examinational to mulliad at	Completed	15. Deceden (Specify only highe	it's Education	4)	16a. Dece	dent's Usual Occupa kind of work done of	ation	t of worki	20	16b. Kind of	Business/Ir	ndustry
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2	orth	Son			5	НО	memaker				Uwn	Home	!
Б	d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name	(First, Middle,	Maiden Suma	me)	
<u>×</u>	Meni Meni	2	George H. Lanc	enfelder				Anna	ì ,	U1	lrich		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Since and the transplant of the transplant in the state of th		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Street a	and Numbe	r or Rura	Route Number	r, City or Town	n, State, Zip	Code)
≥ .	and salth n 27 ner tr		Nick Helms/sor]			5 Falls R		Cock	eysvill	.e, MD.	210	30
Baltimore,	of Ho of Ho fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Demonstration	20b	 Place of Dispo cemetery, crer 	sition (Name of natory or other place	e)			20c. Location	- City or To	own, State
Ĕ	Pag nent ant: i		'4 □Donation 5 ☑ Other (S	Specify) Entor		Dulane	y Valley	Mauso	01/2 Jeum	7/2005	Timon	ium.	MD -
at	permit. Departr Importe any inju		21. Signature of Funeral Service			22	. Name and Addres	s of Facility	Ruc	k Towso			
m	20E 2 3		Vely Co De	Stota	ephen C		1050 York						204
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the de								Approximate
	nysician :		Immediate Cause (Final	M .	book.	+:	Pina	60.	, ,	-			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	o (or as a cons	equence of).	wing	un	cel			-	
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		ĕ	if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	equence of):), 0	00				
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o,	executin an ial-tr	Exa	resulting in death) Last	Due to	(or as a cons	equence of):							
58760,	icate be executed physician and s the burial-transit	dicai		d.									
	tifica g ph as th	a											
Вох	leath certific ettending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of preg		IP.,				23d. Da	ate of delive	ery
<u>m</u>	deat e ette	icia	in the past 12 months? 1 ☐ Yes 2 █ No	4□ Preg	birth 2 ☐ Fe jnant at time o		Ectopic pregnancy Other (specify)					onth	Day Year
о. О	t the by th ache	hys	9 Unknown	9∐ Unk	nown								
·,	The law requires that the death certifies has been signed by the ettending vage 2 should be detached for use as	by P	Part II. Other significant condition	ons contributing to	death but not r	esulting in the ur	iderlying cause give	n in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?
Records,	w require been sig should b									1 □ Ye	s 2 🗆 No	3 Prob	ably 4 Unknown
ပ္ပ	s bae	Completed								24a. Was a	n 24b.	Were auto	psy findings available
He He	he lav e has age 2	E								autops perform	y ned?	prior to cor death?	mpletion of cause of
			25. Was case referred to medical					00 01			No No	1 🗆 Yes	2□ No
>	sick cert irect	o Be	examiner?	Hospital:	Inpatient 2	DED/Outration	Othe	-		(Check only on	-		
ō	Physic representation of the standing of the s	H	27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	28c. Injury	4 14013	_	e 5 Keside 8d. Describe ho			y)
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2	death. ctor: A y the fu	flca	3 ☐ Suicide 6 ☐ Could r	not be	e of Injury - At	home farm stre	et, factory, office		-	8f Location (St.	reet and Numl	ar or Pura	l Route Number,
Division of	after Dira	Certification;	4 ☐ Homicide determ	build	ding, etc. (Spe	city)	ot, raciory, orno			City or Town	, State)	on or mura	r noute raumber,
:	spite ours nerei fillec		29a. Certifier 1 Certifyin	g Physician: To th	e hest of my k	nowledge death	occurred at the time	o dato and	I place a	ad dua to the or			
:	24 h	Medical	(Check only 2 Medical I	examinar: On the	basis of examin	nation and/or inv	estigation, in my op	inion, death	occurre	d at the time, da	ate and place,	and due to	the cause(s)
	I of the hospitel or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certification of the funeral Director. After this certification by the funeral director.	Me	29b. Signature and (Ne of certifier			^	29c. License	number		29	d. Date signe	d (Month. i	Day, Year)
	->-0				- M	1)	170	1153	6		1170	161	
		-	30. Name and address of person	who completed es-	so of don't /**	am 23a) /T '	Print)	117			.103	100	
	10		A La MIT	1 7 A	C/ I	oni zoa) (Type, I	Rand	· P	11/1	Ra	1hin	1	PES15 (1-
	Sta	e	31. Date filed (Month, Day, Year)	32.	gistrar's Sig	nature		V(13	LVC	(10	111.00	211	10100
	Registra	_	JAN 2 6	2005	Calva	K A	realed						

amend item#7, perfh (3839, 1/28/05) II III Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene State amend item#5, perFH, G840, 2/8/05 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Charles Hilary Hayden January 21, 2005 4:10PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6805 Tilden Lane Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Months Days Hours Min. 1**∑**M 2□F Director Yrs 82 81 August 14, 1922 Maryland Usual Residence of Decedent 2 should be filled within 72 hours after death with the Maryland n and Mental Hygiena. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be putified at Completed by Funeral Director Montgomery 1 ☐ Yes 2 ☑ No Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6805 Tilden Lane 20852 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No WWII,
If Yes, Give Korean
Year or Dates: Conflict. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) United States Navy College (1-4or 5+) 4 Commander 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles P. Havden ျှ Mary Dick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 signature of Health and tant: If item 27 is pury or other traur Ann Maccombs Hayden/Wife 6805 Tilden Lane, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 25, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ^¹ 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc Bethesda, Maryland 2005 22. Name and Address of Facility Lalla Albers Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M001420 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiorespiratory Arrest minutes /Medical Due to (or as a consequence of): Examiner Metastatic Cancer to Brain months if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: Tha law requires that the death certificate be executed Malignant Neoplasm of Lung months Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown signad by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Parkinsonism 1 ☐ Yes 2 ☐ No 3 🛱 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate I 1 ☐ Yes 2 ☐ No 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 🗓 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? After 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral D 1💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 January 24, 2005 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna Rinis, M.D., NNMC, 8901 Wisconsin Avenue, Bldg 9, First Floor#1697, Bethesda, Maryland 20889 31. Date filed (Month, Day, Year)

JAN 2 6 2005 32 egistrar's Signature State Registrar

COSE	HAMASI.	AIN	1- State of Ma State Unpend Item 23a, pt.II,	ryland / De 27 per m	partment of Health e G839 1-28-05 ertificate of Deatl	and Mental Hy tas	ygiene Reg. No. 200	5 01864
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of D Month	Day Ye	
	/Media	al		sian	4h City Town or Location	JAN.	23, 2005 4c. County of D	
	Examir	iei	4a. Facility Name (If not institution, give street and number)		GERMANTOWN		MONTGOM	ERY
83	Funeral Director		091-24-0703 1□M 2⊠F	(In yrs. last birthd 73 Yrs	Months Days Hours	Min. 8. Date of B (Month, D Septemb		Birthplace (State or Foreign Country) W York
\rightarrow	/land		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	e Man	ctor	Maryland Montgomery	Germant	own			1 🎇 Yes 2 🗆 No
	with th	Dire	10e. Street and Number		10f. Zip Code 20874		10g. Citizen of What	
	ns 23.	Funeral Director	12935 Bridger Drive 11. Marital Status 12. Was Decedent E	ver in U.S.		rigin? (Specify Yes or N	United St	merican Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exertiting right by roulified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Norced 1 ☐ Yes 2 ☐ Norced 1 ☐ Yes 2 ☐ Norced 1 ☐ Yes Grant Or Dates:	>	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 X No Specify		Specify:	White, etc.
15-0	natu "natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occupation live kind of work done during mo e. DO NOT use retired)	est of working	16b. Kind of Busine	ss/Industry
212	d within	Completed	Elementary/Secondary (0-12) College (1-4or 5+	-1	feteria		Public S	chools
nd	oe filec al Hyg d othe	Be	17. Father's Name (First, Middle, Last)			ner's Name (First, Middle	e, Maiden Surname)	
y Ja	d Meni narke	၉	Narair Garabedian	405 14		· · · · · · · · · · · · · · · · · · ·	unknown)	
	Ith and 2 sl	1 2	19a. Informant's Name/Relationship (Type, Print) George Hamasian / Husband		ailing Address <i>(Street and Numl</i> 35 Bridger Driv			
lore,	iges 1 au nt of Hea If Item or othe	H	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other place)	January 28,	20c. Location - City	or Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		y Crematorium, Inc. 22. Name and Address of Faci Robert A. Pumphrey 300 West Montgomer	2005 Funeral Home	Bethesda,	
	207 29		UnglateBarnet					
	Physician		23a. Part1 (Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Intestina			s cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a	consequence of):				
	p ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):				
_,	axecute	Examiner	that initiated events C.	consequence of):				
68760,	te be (ysiciar ne buri	edical E	d					
89 x	ertifica ling ph e as th	Med	IF FEMALE:					
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of Month	delivery Day Year
S,	es thai gned b	by P	Part II. Other significant conditions contributing to death but	_	e underlying cause given in Part	I. 23e. Did	tobacco use contribute	e to the cause of death?
ord	requir een si hould I		Hypertensive Cardiovascular	Disease		1 -	Yes 2 No 3	Probably 4 Ninknown
of Vital Records,	ding Physician: The law h. After this certificate has b funeral director, page 2 s	Completed	25. Was case referred to medical			1 XYes	opsy ormed? death 2 No 1 No	
Ξ	yslcia is certi directo	To Be	examiner?	t 2 ER/Outpa	201	e of Death Check onlursing Home 5 Res		pecify) AT SCENE
0 0	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day)	28b. Time	e of 28c. Injury at		how injury occurred	
Division	ttendi death. stor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	At home form	M 1 ☐ Yes 2 ☐ street, factory, office		(Street and Number or	Charal Courte Attached
	al or A s after il Direction by	Certification;	4 Homicide determined 200. Place of injur- building, etc.	(Specify)	Street, factory, office	City or To	ewn, State)	rurai rioute Number,
	ne Hospitt 24 hours ne Funera	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of and manner state	examination and/or	eath occurred at the time, date a r investigation, in my opinion, de	nd place, and due to the ath occurred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier Caral Halla C	end	29c. License number O.C.M.E			4, 2005
			30. Name and address of person who completed cause of dec	ath (Item 23a) (Tyr	STREET, BALT	IMORE.MARYL	AND 21201	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Restrar JAN 2 5 2005	's Signature	Gode			
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			1 - For State Registrar	State of Mary		artment of rtificate of			ene	. nioce
	Physic		1. Decedent's Name (First, Middle, La	+ ENCE				2. Date of Death	Day Ye	3. Time of Death 2
	/Medi Examii		4a. Facility Name (If not institution, giv	e street and number)	····	4b. City, Town	, or Location of Deat	h day	4c. County of D	
	E		5. Social Security Number 6. S	Hospital	yrs. last birthday)	BA /	fmore	City 8. Date of Birth	NIA	Piahalas (Out.)
	Funeral Director			□M 200 F	13 Yrs.	Months Day		8. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
	anyland ahow	_	10a. State 10b. County	100	c. City, Town or Lo					10d. Inside City Limits
	the Ma 28a-f	by Funeral Directo	Maryland N/A 10e. Street and Number		Balti	10f. Zip Code		10	g. Citizen of What	Yes 2 No
	th with	al Di	1959 W. Lexin	igton St.		101. Zip C004	21201	1	U, S.A.	Country
	iteme	uner	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puerl			merican Indian, hite, etc.
900	ours af	1 by F	3 Widowed 4 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:		1□Yes 2¶N	o Specify:		Specify: B	lack
215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23s or 28s-f show ins Mydical Expiration must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of wor red)	rking	6b. Kind of Busine	ss/Industry
21	filed with Hygiene. other than	Comp	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		us e Kaep			NIA	
and	ould be filed with Mental Hygiene. arked other than atic event, Link	Be	17. Father's Name (First, Middle, Last) William Gr	een				ne (First, Middle, Mi Grech		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f ahow other traumatic event, I'm Mydical Exameter must be notified at	2	19a. Informant's Name/Relationship		19b. Mailir		et and Number or Ru	ral Route Number,	City or Town, State	
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mor	Pages nent of I int: If It		1 ☐ Burial 2 A Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Indinoval Holli State	Ob. Place of Dispo cemetery, crem METRO	natory or other pl	ace)	22-05 E	Oc. Location - City	
Baltimore	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		21. Signature of Fune All Service Licer		22 V	Name and Add	ress of Facility U. BROWN	community		
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a cor						
o,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	\				
09289	ate ye he	Physician/Medical		d. 177 PO	Tensio	74				
Box (eath certifica attending pl	an/Me	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		Ectopic pregnan	m.		23d. Date of c	delivery
.O. E	the death by the atte	ysici	in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (specify)	~y		Month	Day Year
G,	res that the igned by be detact	by Ph	Part II. Other significant conditions of	ontributing to death but not	t resulting in the ur	nderlying cause g	iven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	w require been sig should t							1 🗆 Yes	2 No 3	Probably 4 Unknown
Records,	The law ate has t page 2 s	Completed						24a. Was an autopsy performe	prior to	autopsy findings available o completion of cause of ?
		Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	No 1□Y	es 2DNo
o	Phys	. To	1 ☐ Yes 2 ☐ Who 27: Magner of Death	28a. ate of Injury	2 ER/Outpatien 28b. Time of	t 3 DOA O		ome 5 Residence		pecify)
ion	Ntending P death. ctor: After y the funera	ation	1 Swatural 5 Pending investigation	(Month, Day Yea	(r) Injury	Wo	ork?]Yes 2 □No	25d. Describe flow	injury occurred	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, stre pecify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or i State)	Rural Route Number,
	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) (Check only one)	ysician: To the best of my liner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred at the trestigation, in my	ime, date and place, opinion, death occur	and due to the causered at the time, date	se(s) and manner and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	∑	29b. Signature and title of certifier	2 20. 1)	29c. Licen	se number	29d	I. Date signed (Moi	nth, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

Month

ANNUARY AD, on 1

4c. County of Death **Physician** HORACE MARION HILL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore General Maryland If Under 24 Hrs. 5. Social Security Number s. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In v 6 Sex **Funeral** Days Months Hours tXXM 2□ F 251-16-5951 SOUTH CAROLINA 88 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 3900 REXMERE RD. 21218 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2XXNo Specify: Specify: BLACK 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, I.a Medic once. Elementary/Secondary (0-12) College (1-4or 5+) GENSTAR LABORER 8th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY CUNNINGHAM HOMER HILL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3900 Rexmere Rd., Baltimore, Md., 21218 Paul Edwards Jr./ Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 01-29-05 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 21. Signature of Funda and 22. Name and Address of Faculty WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Squamous Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** acunoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Dinknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed After this certificate funeral director, pag 200 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA Medical Certification: To 2 ER/Outpatient 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: . completely filled in by the f 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.O. Liana ghaa 32. Registrar Signature 31/Date liled (Month, Day, Year) State 2005 J. September Registrar

	1- For State of Maryland / Department of Health and Mental Hygiene O 5 0 186 Certificate of Death	67
Physician /Medical	1. Decedent's Name (First, Middle, Last) Mathieu Joseph Haslbeck 2. Date of Death Month Day Year 1944	ath M
Examiner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 200-07-9853 12 M 2 F 82 Yrs. Months Days Hours Min. NOV 2, 1922 Mary Land	oreign
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buter death with the Maryland are tems 23a or 28e-f show nirer must be notified at Funeral Director	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
heath wi	1001 South Main Street 21014 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,	
5 <u>2 3 1,5</u>	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Poecify: White	
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A D / C S 9. Marylan and 2 should be lealth and Menta m 27 is marked her treumetic ev	Regina A. Haslbeck / Wife 1001 South Main St., Bel Air, MD 21014	
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hyghen. Importent: if item 27 is marked other then any injury or other treumetic event, Iza M page. To Be Comp	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State	
Balti permit. Departn Importe any inju	21. Signature of Energial Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland	
Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Dea	en Ith
/Medical Examiner	disease or condition resulting in death) a. Therefore the forest and the forest	
# 367618 B760, cale be executed physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	
5. Box 6 be death certified the attending placed for use as secon	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	r
rds, P. quires that an signed build be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Durke	
Math le	24a. Was an autopsy findings avaing autopsy performed? 1 Yes No 1 Yes 2 No	ilable e of
f Vita of Vita hysicien his certifi I director	25. Was case referred to medical examiner? 1 Yes 2 To Hospital: Topatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
() 0 = 5 5 7	27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	
ASIBEC Division of Spatial of Attending Property filled in by the funeral property of the funeral property filled in by the funeral certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
he Hospii in 24 hour he Funer pletely fills	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To the within To the Committee of the Co	29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Auche 1 The PhD D 500 40 01-73-2005	-
19	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State Registrar	Claudia A. Kroker, MD, FACP, PHD, 1308 Business Center Way, Edgewood, MD 21040	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Johnson Charles 545 P M DI 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Frederick Villa Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**万**M 2□F 231-46-2187 T2 Yrs. NC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumatic event, the Medical Evaniner must be notified at MD Baltimore 1 KiYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WOLF 21213 STREET USA 1719 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Importent: If Item 27 is marked other then "natural", or Items 23e any injury or other treumstic event, the Medical Example research 2008. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specify: BLACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 12th grade CONDUCTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tillman Johnson Della Lockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sulvia Sumpter 214 Timber Lane Graysonville MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State DI: 29.05 Woodlawn, MD WOODLAWN * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Valley C. Greene Funeral Services
5151 Baltimore National Pike Baltimore ND 21227 21. Signature of Funesal Service Licens 23a. Part 1. En ar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Linknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 NO To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Urursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: Manne of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cert 36942 Gfarsille, Ms 21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) freduick Rd KHIA. My) 1009 22 Registrar Signatus 31. Date 1 A North, toy, 2017 State Registrar

		For	State of Mary	•			Mental Hyg	giene,	OF	01000
		1 - State Registrament ITEM #	26 PER VERI	в с839 ^С е	THEFTS OF	Death		leg. No:-	UD	01869
Physi	cian	1. Decedent's Name (First, Middle, Last) Maria M. J	acobson				2. Date of Dea Month	Day	Year	3. Time of Death
/Med Exam		Maria M. J 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	January	1	nty of Death	/:UUP
Exam	mer	4620 N. Park Ave		E	Chevy Cl				tgome	
Funera	1	Social Security Number	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	3		place (State or Foreign intry)
Directo	r	0/2-10-9568	M 2 🗓 9 :	2 Yrs.			Oct. 29,	1912	New	York
land		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation					10d. Inside City Limits
Mary -1 sh	to	Maryland Montgomer	y	Chevy Cha	ase					1 X Yes 2 ☐ No
h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?
th wit	aiD	4620 N. Park Avenu	e, Apt. 150	O8 E.	20815			Unite	d Sta	tes
er dea	nuel	T. Maria Galas	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. F	Race - Ameri Black, White,	
36 rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specity:		Spe	city: W	hite
2 hou	Completed by Funeral	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of	Business/In	ndustry
215 Fin 7	pje	(Specify only highest grade	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wo ()	orking			
od wi	Cou	12		Но	omemaker				Home	
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. The marked other then "natural", or treumatic event, the Medical Exami	Be	17. Father's Name (First, Middle, Last) Michael A. Mokarz	61				me (First, Middle, Durham	Maiden Sun	ame)	
thould mark	은	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a			r. City or Toy	vn. State. Zi	p Code) 20815
Ma 2 s lith ar 27 is r treu		Bernard Jacobson/h								Chase, MD
or hear		20a. Method of Disposition	2	Ob. Place of Dispo			Date 25,		n - City or T	
Page Page nent c		1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)		St. Peters	,	20		Poughke	epsie,	New York
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other treumstic event. The Medical Examinar must be notified at		21. Signature of Funeral Service License	/	. 22 1	Name and Addressethesda—Che	s of Facility Ro	bert A. Pur	mphrey	Funeral	Home,
m goes	ol	Milham a. Kung		· J	sethesda, M	lary land,	20814			Approximate
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final					ic or respiratory arr	est,		Interval Between Onset and Death
Physicia /Medica	_	disease or condition resulting in death)	Due to (or as a co	_	y Diseas	e				
Examine				nisequence on).						
	Je J	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of injury	Due to (or as a co	nsequence of):						
ecuted Ind transi	Examiner	Cause (Disease or injury) that initiated events resulting in death) Last								
ox 68760, certificate be executed ading physicien and use as the burial-transit	E E	155uming in dodiny East	Due to (or as a co	nsequence or):						
687 ificate g physi	dicai	0								
Box 6 eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pr		7-			23d.	Date of deliv	rery
. 0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 Live birth 2 4 Pregnant at time		_Ectopic pregnancy Other (specify)				Month	Day Year
P.O. that the dead by the detached	hys	9 🗆 Unknown	9L Unknown							
		Part II. Other significant conditions con Depression	tributing to death but no	t resulting in the u	nderlying cause give	en in Part I.				the cause of death? bably 4 Unknown
cord w requir been si	eted	Бергевыен						T	war and the same	
Re la has	Completed						24a. Was a autop perfor	sv	prior to co death?	opsy findings available ompletion of cause of
- # d	O)	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only or	2 & No	1 🗌 Yes	2 No
- 09	To B	examiner?	ospital:	2 ER/Outpatier	nt 3 DOA Othe	or.	Home 5 Resid		Other (Specia	fy)
		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	f 28c. Injun World	y at k?	28d. Describe h	ow injury occ	urred	_
Vision Attending r death. ector: Afte	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	006 1 10 10	4		
- Fife	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		City or Tow	treet and Nu n, State)	mper or Hura	al Route Number,
Division To the Hospitel or Attenwithin 24 hours after death To the Funerel Director:		29a. Certifier 1 X Certifying Phys	ician: To the best of m	y knowledge, deat	h occurred at the tim	ne, date and place	e, and due to the o	ause(s) and	manner as s	stated.
ne Ho n 24 h ne Fur	edical	(Check only 2 Medical Examination)	ner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my of	pinion, death occ	turred at the time, o	late and plac	e, and due t	to the cause(s)
To the Hospitel of within 24 hours at To the Funerel Completely filled in	M	29b. Signature and title of certifier	9		29c. License			29d. Date sig		* ' '
		loge.	XI/au	3 MD	D29	353		Januar	y 24,	2005
		30. Name and address of person who co				#025	Charry Ol		a 1 -	1 2001 F
	State	George W. Graves, 1	2 Registrar's	Signature	n Avenue,	11925,	onevy Cha	ise, M	aryıan	nd 20815
Regi		JAN 2 6 2005	Store ,	& spen	les .					

			1- For State of Maryland / Department / Department / Depa	artment of Health and Martificate of Death	lental Hygie Reg.	4000	01870
	Physici /Medio		Decedent's Name (First, Middle, Last) GERALDINE	JACOBS	2. Date of Death Month JANUARY 2	Day 2005	3. Time of Death 9:26 P M
	Examin		4a. Facility Name (If not institution, give street and number) SPRINGHOUSE ASSISTED LIVING	4b. City, Town, or Location of Death PIKESVII If Under 1 Year If Under 24 Hrs.	_LE		TIMORE
	Funeral Director		5. Social Security Number 065-24-3650 065-24-3650 06. Sex 1 M 2 F 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye AUG. 22, 19	9. Birt 930	hplace (State or Foreign untry) NY
	Maryland f show led at	tor	10a. State 10b. County 10c. City, Town or Lo	GS MILLS			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	oth with the Marylan 23s or 28e-f show	al Director	10e. Street and Number 6 BIEHL COURT	10f. Zip Code 21117	10g.	Citizen of What Co	Α
036	72 hours after death with the Maryland netural", or tema 23a or 28e-f show iteal Examinar must be motified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Vas Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No	Was Decedent of Hispanic Origin? (Spet Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian,
21215-0036	within ane. than "	Completed	(Specify only highest grade completed) (Give life, L	lent's Usual Occupation kind of work done during most of worki DO NOT use retired) MAKER	ng	. Kind of Business/	Industry
land	should be filed nd Mental Hygis marked other matic evant, L	To Be C	17. Father's Name (First, Middle, Last) MI CHAEL MITC		(First, Middle, Maid	den Sumame)	NEUMAN
Maryland	d 2 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rura EHL COURT - OWINGW	l Route Number, Cit		
Baltimore,	t in the		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Dispo		oate 20c.	Location - City or RANDALLS	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22		L LEVINSC	N & BROS	., INC.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		r respiratory arrest,		Approximate Interval Between Onset and Death
90,	icate be executed physician and s the buriat-transit	al Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):	3/2///3/3		N	
P.O. Box 68760,	death certii e attending id for use a	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tobacc		the cause of death?
Vital Records,	The ate he page	Completed			24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
Division of Vita	ul or Attending Physician: The after death. Director: After this certificate in by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director, pagin by the funeral director.	Certification: To Be	25. Was case referred by medical examiner? 1 Yes 2 DNo	28c. Injury at 2 Work? M 1 Tes 2 No	(Check only one) ne 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Ste	jury occurred and Number or Rui	Psvisig
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	ed at the time, date a	(s) and manner as and place, and due	to the cause(s)
1	1		Jaseeeu Lallauri 31. vame and address of person who completed cause of death (Item 23a) (Type, FI ASNEEM AKHANI, 7220	138535	- Ant	124/05	- MD21208
4	Sta Registr		31. Date filed (Month, Pay, Year) 6 2005 32. Phistrar's Signature	barle	73 - 700	, 1315A	806 1000

			Aug 1 - For State Registrar	end ista	M fo 9	ary latite		u Rmen Pēf tificate of				jiene eg. No.	00	05	0187
	Physicia /Medic		1. Decedent's Name (First, Midd RAVINDER		UR	-					2. Date of Dea		4 ž	. 0 05	3. Time of Death 7:17A M
	Examin		4a. Fecility Name (If not institution SOUTHERN MAI					4b. City, Town, CLINTON		of Death			County of RINCE		RGES
	Funeral Director	r. sx	5. S 214-06-1143 214-06-3143	6. Sex 1 ☐ M 25		je (In yrs. la 81	st birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. 8 Min. JT	B. Date of Birtl	192	3	Birthpla Countr	ce (State or Foreign y) INDIA
	pu *		Usual Residence of Decedent 10a. State 10b. Counts	,		10c City	Town or Lo	cation						100	d. Inside City Limits
	Maryla f ehon	ŏ		E GEORGE	S		ON HIL								MYes 2 No
	3a or 28a	i Director	10e. Street and Number 6255 OXON H	LL ROAI)	J		10f. Zip Code 20745	;			-	zen of Wh	at Countr	y?
020	s 1 and 2 should be filed within 72 hours after death with the Maryland I fleatth and Mental Hygiene. I fleatth and Mental Hygiene. I fleat 27 le marked other than "naturel", or Iteme 23s or 28s-f show other traumatic event, the Medical Exactions must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Na. 3 Widowed 4 Divorce	rried 1 If Ye	Decedent ed Forces? Yes 2 : s, Give r or Dates:		1	Vas Decedent of Yes, specify Cu	ban, Mexicar	n, Puerto Ri	ify Yes or No- ican, etc.)			White, et	
0-0171	within 72 ho ne. han "netur e Medical	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12)		eted) ege (1-4or	5+)	(Give life. L	lent's Usual Occi kind of work don OO NOT use retir MEMAKER	a during mos	t of working			nd of Busin		
מווח ע	should be filed within a Mental Hygiene. marked other than matlc event, tre Mental matlc event, tre Mental matlc event.	To Be Co	17. Father's Name (First, Middle INDER SINGH	, Last)						er's Name (TAM KA	First, Middle,	Maiden .	Sumame)		
Mai	and 2 should leath and Men m 27 le marks her traumatic	_	19a. Informant's Name/Relation SUKHWANT K. Da			ER		g Address (Stree							Code)
Dalilli Ole,	permit. Pages 1 and Department of Heal Importent: If Item 2 any injury or other ODICE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (-		from State	BALT	ace of Dispo metery, cren [• -WAS	sition (Name of natory or other pi H - CREMA	TORY1-	-27-05			cation - Ci EL, M	1	n, State
Dall	permit. Departn Importe any inju		21. Signature of Funeral Septica	Licensee WWH				. Name and Add					-		
	Physician /Medical		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause	MET!	ine.	TIC	A DENO					AST	1	Approximate nterval Between Onset and Death
	Examiner	ner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying	b	ue to (or as	a consequ	ence of):								
Ď,	ate be executed hysician and the burial-transit	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as	a consequ	ence of):					·			
,00/00	physic the D	dicai		d											
O. DOX	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	10	Live birth	of pregnar 2 Fetal It time of de	death 3□	Ectopic pregnan Other (specify)	су			2	23d. Date of Month		y Yay Year
corus, r.	w requires that the s been signed by t should be detach	by	Part II. Other significent condit	ions contributin	to death t	out not resu	lting in the ur	nderlying cause g	iven in Part 1			baccou: es 2⊈			cause of death?
ב ב	The law red ite has bee bage 2 show	Completed									24a. Was a autop perfor	sy	prio	ore autops or to comp ath? Yes 2	sy findings available oletion of cause of
VII	cian: ertifica ictor, p	BeC	25. Was case referred to medic examiner?							of Death (Check only o				
5	Physician: r this certificaral director,	10	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital:	1 Inpati		R/Outpatien	1 3LI DOA			e 5 🗌 Resid	_			
VISION	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Could	ing tigation	(Month, Da	ay Year)	Intury	M 1[∃Yes 2□	No					Route Number,
2	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide deter		building, e	tc. (Specify,)	eet, factory, office			City or Tow	n, State))		
	the Hosp hin 24 ho the Fund hpletely f	Medical	(Check only 2 Medice one)	I Exeminer: On and		of examinati		occurred at the vestigation, in my			d at the time, o	late and		d due to t	he cause(s)
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	0-		30. Name and address of person						., .	ND	20	ני קו			
	Sta		31. Date filed (Month, Day, Yea		32. Regist	rar's Signat	ure	LINTO	A 1	٠٠ ت	20	13	2		
DH	Regist	_	J	AN 2 6	2005	Mese	was h	7. Ansa							

ORIGINAL

			1 - State RegistrarAMEND TT 1. Decedent's Name (First, Midd	M #10e PER		_				d Mental Hy	Reg. No. 20	05	018	3.72
	Physici /Medic	cal	FELA				KAPL			JANUAR	Y 23, 20		3. Time of 3:45	P M
	Examir	ier	4a. Facility Name (If not institution COPPER RIDGE 5. Social Security Number	NURSING HO	ME	last birthday)	4b. City,		SYKES If Under 24 I	VILLE	4c. County	CARE	ROLL	
	Funeral Director		162-30-4356 Usual Residence of Decedent	1□M 2₩F	90		Months	Days		Hrs. 8. Date of Bi Min. 0CT.6,	1914	9. Birth Cou	place (State or ntry) PO	LAND
-	Ba-f show	Director	10a. State 10b. County	CARROLL	10c. Ci	ty, Town or Lo	cation SVILL	E					10d. Inside City 1 ☐ Yes	,
div. dt	s 23a or 2	ral Dire		ROAD			10f. Zip		21784		10g. Citizen of V	Vhat Cou	ntry? USA	
in in 12-0030	natural', or Itams 23a or 28a-1 show udical Examinat must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	es? No		Vas Deced fYes, spec I□Yes 2	_	spanic Origin? n, Mexican, Pi Specify:	(Specify Yes or No Jerto Rican, etc.)	Specify	k, White,	can Indian, etc. WHITE	
0 Z 1 Z 1 3-0030	tal Hygiene. Id other then "nature event, the Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4	or 5+)	life. I	lent's Usual kind of won DO NOT use MAKER	k done di	uring most of	working	16b. Kind of Bu		dustry	
ylan		To Be	17. Father's Name (First, Middle, UNKNOWN)				NOWN)		(UNKN			(UNKNOWI	N)
	Health a am 27 is thar trau		19a. Informant's Name/Relations HARRIS KAPLAN 20a. Method of Disposition	/ SON			BUTLI	ER R	OAD -	P.O. BOX Date		NDON	, MD 2	1071
Description of the control of the co	partment of portant: If y injury or		1 Burial 2 Cremation 4 Donation /5 Other (S	pertly)	ate	LOM ME	MORIAI . Name and	L PA	RK 01,	/26/2005 SOL LEVI WN ROAD -	NSON & E	ROS.		
	hysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	sed the deat h line.	h. Do not ente							Approximate Interval Betwo	reen
licate be executed	miner transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last	С	as a conseq	,								
death cediff	e attending ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moords? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ∏ Feta tat time of d	Ideath 3	Ectopic pre Other (spe				23d. Date Mon		ery Day Ye	ear a
	been signed b	ed by Ph	Part II. Other significant condition	/	h but not res		derlying car		in Part I.		obacco use contri res 2 No			/
The	ate h page	Completed by			-					24a. Was autor perfo 1 - Yes	rmea?	ere autorior to consath?	psy findings av	railable use of
na Physician:		on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	Hospital: 1 ☐ Inp		ER/Outpatient 28b. Time of Injury		Other	4 Nursing	Peath (Check only of Home 5 Residence 1986) Residence 1986. Describe to			')	
l or Attendina	i i te	Certification:	2 Accident investigned Accident investigned Accident Acci	not be 28e. Place of	Injury - At ho	ome, farm, stre	M et, factory,	1 🗆 Y	es 2 No	28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rura	l Route Numbe	<i>ЭГ</i> ,
Hospita	within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the be Examiner: On the basi and manner	s of examinal	wledge, death tion and/or inv	occurred at estigation, i	t the time n my opia	, date and pla nion, death or	ice, and due to the courred at the time,	cause(s) and man date and place, a	ner as st	ated. the cause(s)	
To the	withii To th comp		29b. Signature and title of certifier	2. M.	٠-,	mo		License (number 2 PP \		29d. Date signed	(Month, I	Day, Year)	
1	1		30. Name and address of person	who completed cause of		23a) (Type, F	Print)			1. 1	?. P-	-/	/	11

Pothert Known OS Amaham Isaac Klein

Baltimore Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		. For	State of M								gible.	01070
		1 - State Registrar			Ce	rtificate	of De	ath		Reg. No: U	U5	01873
Physic /Medi		Decedent's Name (First, Middle, L ABRAHAM	ast)	ISAA	С	K	LEIN		2. Date of De Month January	ath Day 24	Year 2005	3. Time of Death
Exami	ner	4a. Facility Name (If not institution, gi				4b. City, 7	Town, or Loc	ation of Deal		4c. Cour	nty of Death	
Funeral			of Balting		last birthday)	If Under	1 Myre	Under 24 Hrs	8. Date of Bin	th.	O Dist	N/A
Director			1 M 2 □ F	81		Months		ours Min.	FEB. 23	, 1923	9. Birth	DIACE (State or Foreign AUSTRIA
irylanc ihow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	10d. Inside City Limits
he Ma 8a-f	Director	MD N/A			BALT	IMORE						.¹ X Yes 2 □ No
death with the Maryland ms 23a or 28a-f show rmust be notified at		10e. Street and Number 3304 PINKNEY RC	IAD.			10f. Zip		1015		10g. Citizen o	f What Cour	
death ms 23	Funerai	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. 1	Was Decede		21215 nic Origin? (S	pecify Yes or No	- 14. R	ace - Americ	USA can Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-f show any injury or othar traumatic avent, the Madical Examinar must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🏋 If Yes, Give Year or Dates:		1	lf Yes, speci 1 ☐ Yes 2		exican, Puèr pecify:	pecify Yes or No to Rican, etc.)	Spec	lack, White,	
72 hc	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	dent's Usual	Occupation	a most of wo	rkina	16b. Kind of	Business/In	dustry
within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)			retired)	g most of wo	All 19	CANDY	E 4 C E C	DV
filed Hygie othar		17. Father's Name (First, Middle, Las	·)		OWNE	ĸ	18	Mother's Nar	ne (First, Middle,	CANDY Maiden Sums		KY
lid be fental rked c	To Be	SIMCHA			KLEI	N		ACHET	no (i not, imagio,	Walder Some	iney	GRONER
2 should and Men Is marke aumatic	_	19a. Informant's Name/Relationship	Type, Print)						ıral Route Numbe	r, City or Tow	n, State, Zip	
and 2 ealth m 27			ON					AD - E	BALTIMORI	E, MD 2	21215	
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 (Removal from State	C	lace of Dispo emetery, cren	natory or oth	ner place)		Date	20c. Location		
it. Pa intmer intant njury		* 4 □ Denayion 5 □ Other (Special Service Uca	9)	BET	H MOSE				25/2005			
permit. Departr Importa any inje		1 INNOV	MILLAGA		. 0	Name and	Address of	Facility S(L LEVINS	SON & E	ROS.,	INC.
7		23 Pal 1. Enter the disease, or com shick, or heart failure. List only	polica un sinat caused	the death							LLE,	MD 21208 Approximate
Physician	H	Immediate Cause (Final							,,			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Non Sm. Due to (or as	a consequ	uence of):	umuo	ICT	ung				
Examiner		Sequentially list conditions.	b									
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rtificat ng phy as th			V									
The law requires that the death certifical ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy				ate of delive	ry
ne deg the al	/sici	1 Yes 2 No	4☐Pregnant at 9☐ Unknown	time of de		Other (spec				М	onth	Day Year
w requires that the d been signed by the should be detached		Part II. Other significant conditions of	ontributing to death b	ut not resu	ıltina in the un	nderlying cau	ise given in f	Part I	23e Did to	hacco use cor	tribute to th	e cause of death?
uires sign ild be	d b		+ failure			,,	g			es 2 □ No		ably 4 \(\begin{array}{c} Unknown \end{array}
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The tav te has age 2	Completed by								autops perfor	med?	prior to con death?	osy findings available inpletion of cause of
	BeC	25. Was case referred to medical					26. I	Place of Dea	1 ☐ Yes	2 1 No	1 🗆 Yes	2 1 No
Physic this ce al direc	70	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 🗆 E	R/Outpatient	3 □ DOA	04		ome 5 Reside		her (Specify)
ing Ph	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	280	. Injury at Work?		28d. Describe ho			
Attending Physician: r death. ector: After this certific by the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not b	A			М	1 🗌 Yes	2 🗆 No				
l or A after Direc in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	Iry - At hou :. (Specify	me, farm, stre	et, factory,	office		28f. Location (St City or Town	reet and Num. n, State)	ber or Rural	Route Number,
To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funer.	Medicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysicien: To the best on the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at estigation, in	the time, da	te and place, death occur	and due to the cared at the time, d	ause(s) and m	anner as sta	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	and mariner sta	teu.			License num			9d. Date signe		
1				D/			5-0			nuary a		
1/1		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, P				00	riumy o		
71		Jottsinvchen,	DO	Sina	i Hosy		of Ba	Homer				
Sta		31. Date filed (Month, Day, Year)	32. Registe	r's Signati	ure	,						
Registra	ar	JAN 2 6	2005	Sec. 1	M.	Firesoft.	1					

		RegistraMFND ITFM 1. Decedent's Name (First, Middle, La		339 I/Z	ertificate of	•	2. Date of Dea	eg. No.	3. Time of Death
Physic Medi/		Waneta	Læ	w			Month (Day Year	
Exami		4a. Facility Name (If not institution, given	ve street and number)	1	4b. City, Town, o	or Location of Death		4c. County of Dea	
		Riverview Care Co		n yrs. last birthda	Essex	If Under 24 Hrs.	10 D (B)	Baltimo	
uneral irector		-	1 □ M 2 □ XF	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Fore
		Usual Residence of Decedent					05105	III × > We:	st Virginia
shoy	5	10a. State 10b. County		Dc. City, Town or					10d. Inside City Lim
28a-1	ecto	Maryland Baltimon	re	Middle					1 ☐ Yes 2 💢
3a or	Ö				10f. Zip Code		1	0g. Citizen of What C	country?
item 27 is marked other then "natural", or items 23s or 28s-f show other traumetic avent, the Modical Examinations by multiped at	Funeral Director	4 Strut Court 11. Marital Status	12. Was Decedent Eve	or in U.S. 13	21220 3. Was Decedent of H Il Yes, specify Cub			U. S. A. 14. Race - Am	erican Indian,
or Ite	Fu.	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 X No If Yes, Give		II Yes, specify Cub. 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, Whi	ite, etc.
ural',	Completed by	3 X Widowed 4 □ Divorced	Year or Dates:					Specify: WI	hite
"nat	jete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	cedent's Usual Occup ve kind of work done . DO NOT use retire	oation during most of work	ing	16b. Kind of Business	s/Industry
The M	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		orv Worke			Electron	
d othar then " avant, the Me	BeC	17. Father's Name (First, Middle, Last	1)	Tact	OLY WOLKE	18. Mother's Name	e (First, Middle, N	Electron:	ics
arked etic a	To	Earl Swisher				Mamie	Boyce		
ls m		19a. Informant's Name/Relationship ((Type, Print)	19b. Mai	iling Address (Street	and Number or Rura		City or Town, State.	Zip Code)
thar tr		Nancy Lee Craycra 20a. Method of Disposition		r) 404_	Wolf Stre			nd 21221	
	1 3	1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cri	position (Name of rematory or other place	сө)	1/27	20c. Location - City or	Town, State
Important: any injury c once.		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices			11 Memori		s 2005	Baltimore,	Maryland
Impo any ir				B	22. Name and Addre	i Funeral	Home PA		
19		MICHAEL C. SAI	inlications that caused the	per dvr'	407 Old E	astern Ave	enue Es	sex, Mary	land ZiZZi
sician edical		Immediate Cause (Final disease or condition resulting in death)	a. Huparteu	sine Ar	nter the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:35A [™] 22, Chong Jan. 2005 Chul Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Randolph Hills Nursing Center Wheaton 8. Date of Birth (Month, Day, Year Dec. 10, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** 1938 Korea 66 Director 213-29-7661 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State s 1 and 2 should be filed within 72 hours after death with the Marylar if Heath and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Madrel Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Rockville Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20853 12630 Viers Mill Rd. #1006 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Specify: Asian 1 ☐ Yes 2€ No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit Pages 1 and 2 should be fili Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be Unknown Gi Bok Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10606 Regent Park Crt. Fairfax, VA 22030 Jong Kim (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Fairfax Memorial Park 1-25-05 Fairfax, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fairfax Memorial Funeral Home Ltech 9902 Braddock Rd. Fairfax. 22032 23a. Párt1. Enter the diséase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONE hour **Physician** a HCUTE HEART disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque of) Examiner Physician: The law requires that the death certificate be executed IA DEFES YEARS attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed peen ; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.2 No page 2 has certificate 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? the funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ဥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0021033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGIA AVE. SILVER 13000 OUNG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla		artment of				giene 0	05	01876
			1. Decedent's Name (First, Middle, Last)				T	2. Date of De	ath		3. Time of Death
	Physic /Medi		MAMIE T. LAZZARO					}	1-24-20	05 ^{Day}	Year	8:30 a M
	Exami		4a. Facility Name (If not institution, give 8232 PHILADELPHIA			4b. City, Town	n, or Location DALE	of Death			nty of Death	
	Funeral Director		213 03 3004	7. Age (/n y	rs. last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birt (Month, Da 12-21	n. Year) -1913	9. Birthp	place (State or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					1	0d. Inside City Limits
	Mary -I sh	ţō	MD. BALTIMON	RE]	ROSEDALI	3						1 ☐ Yes XXNo
	h the	Director	10e. Street and Number			10f. Zip Cod	le			10g. Citizen o	of What Cour	ntry?
	th wit	a D	8232 PHILADELPHIA	RD.		21237	7			U.S	.A.	
9036	in 72 hours after death with the Maryland "naturel", or items 23a or 28a-f show ledical Evaria scrimative notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	uban, Mexica	n, Puerto F	cify Yes or No- Rican, etc.)	В	ace - Americ lack, White, city: WHIT	etc.
5-(72 h "natu	ete	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Oci kind of work do	ne during mos	st of workin	ng	16b. Kind of	Business/Ind	dustry
121	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use ret MAKER	tired)			OWN HO	OME.	
d 2	Hygi ther int, 1		17. Father's Name (First, Middle, Last)		TIONE	, LICHTLIN	18 Moth	er's Name	(First, Middle,			
Maryland 21215-0036	should be ind Mental marked o	To Be	Unknown	DiDomenico			L	eana	(Uì	nknown)	
Mai	9 9 9	1 8	19a. Informant's Name/Relationship (Ty LOUIS LAZZARO / SO			ng Address (Stree PHILADE						Code)
	s 1 and 2 if Health item 27 i		LOUIS LAZZARO / SC 20a. Method of Disposition		. Place of Dispo	sition (Name of			ate	20c. Location		wn State
OE	Pages nent of ant: If its ary or o		1X Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ST		SLAUS C		1–26–	-2005 1	BALTIMO		
Baltimore,	permit. Pages D. partment of Importent: If it any injury or o		21. Signature of Funeral Service License	e / hata	22	. Name and Add	dress of Facili	ty CVAC	H/ROSEI	DALE FT	NERAL	HOME
			23a. Part1. Enter the disease, or compli	cations that caused the de					SEDALE,		21237	Approximate
}	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons) AGE	75)	MEL	レノて				Interval Between Onset and Death
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687	ficate physics the	edical	d									
Box	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of preg	etal death 3	Ectopic pregnar					ate of deliver	y Day Year
o.	the d	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)						
S, D	Se un ec	by	Part II. Other rignificant conditions con	tributing to death but not re	esulting in the un	derlying cause (given in Part I.		23e. Did toi			e cause of death?
Record	w require been si should?	lete	· · · · · · · · · · · · · · · · · · ·						24a. Was a			
	The taw ate has page 2 :	Completed							autops perforr	ned/	death?	sy findings available ipletion of cause of
Vital		0	25. Was case referred to medical				26 Place	of Death	1 Yes 1	No No	1 ☐ Yes	2∐ No
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0	ding PI J. After tt funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. inj			d. Describe ho		rred	
Sio	Vitendi death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1	□Yes 2□1	-				
Division of	tel or Attences after death	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office	:0	28	3f. Location (St City or Town	reet and Num n, State)	ber or Rural	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	ician: To the best of my kiler: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the estigation, in my	time, date an y opinion, deat	d place, ar	nd due to the ca	ause(s) and mate and place,	anner as sta and due to	ted. the cause(s)
	To ti Withi To ti comp	×	29b. Signature and title of certifier	\ A	Λ -	29c. Licei	nse number	<i>C</i> :	2:	9d. Date sign	ed (Month, D	ay, Year)
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	2		30. Name and address of person who con	ARNI, M	em 23a) (Type, F	Print) CY	ESACU	m	ve, Bi	270, N	n 212	.37
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	-6:		•		•		
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			1- State Registrar	State of Ma		/ Depa	artme		ealth a	and Me	ental Hy		3005	01877
			Decedent's Name (First, Middle, Last	st)							2. Date of De	ath		3. Time of Death
	Physici		MINYEARN DU	ANTE LE	GRANI	DΕ					JAN	18 ^{Da}	2005	6:20P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)				y, Town, or BALTI		of Death	Ϋ́	4c	County of Dea	ith
	Funeral		Social Security Number 6. S	ex 7. Age	e (In yrs. las	t birthday)		er 1 Year	If Under		B. Date of Bin (Month, Da	th Vaari	9. Bir	thplace (State or Foreign ountry)
	Director		215-84-6904 1 Usual Residence of Decedent	□M 2 ∑ F	31	Yrs.	Month	s Days	Hours	Min.	07/17	7/19	73 MA	RYLAND
	yland		10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside City Limits
	B-f el	tor	MD N/A		BAI	TIM(ORE	CITY	7					XXYes 2 □ No
	death with the Maryland ms 23a or 28e-f ehow ms 15a or 28e-f	Director	10e. Street and Number				10f. 2	ip Code				10g. Cit	tizen of What C	ountry?
	23a	al	2930 INDEPEN	DENCE ST	REET				2121				USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Dec	edent of Hi ecify Cuba	spanic Ori n, Mexican	gin? (Spec 1, Puerto R	ify Yes or No ican, etc.)	-	14. Race - Am Black, Whi	
20	or th	γFL	1 Never Married 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10		1 ☐ Yes	2[X No	Specify:				Specify: D	LACK
3-003p	within 72 hours after ene. then "natural", or ite te Medical Examina	d by	3 Widowed 4 Divorced			160 Doon	dont's He	wal Oanun	ation			16h K	ind of Business	
'n	"nat	lete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of v DO NOT	ual Occupa vork done d use retired	ation <i>during m</i> os	t of working	7	100. K	and of business	vindustry
7	withii then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			OYED				UN	NEMPLO	YED
0	be filed within 72 hours after death with the Marylar Hygiene. d other than "natural", or items 23a or 28e-f show avent, it e Madral Examination us be natified at	ပိ	17. Father's Name (First, Middle, Last)			OIVI	UI11 1	70111	18. Mothe		First, Middle,			
		To B	JOHN GRA	ΔY					DO	ONNE	TA I	LEGI	RANDE	
<u> </u>	shoul nd Ma marl imati	-	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Addre	ss (Street a	and Numbe	er or Rural	Route Numbe	er, City o	or Town, State,	Zip Code)
Ξ	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		MARIE MITCHELL	/ AUNT		422	8 HI	ERREF	RA CI	C., F	RANDAI	LLST	rown,	MD 21133
ē.	s 1 ar if Hea item othe		20a. Method of Disposition		20b. Plac	e of Dispo	sition (A	ame of other place	e)	Da	te	20c. L	ocation - City or	Town, Slale
Ē	Pages ent of nt: If i		1 A Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify					E CE	M	1/24	/05	PIK	ESVILI	E, MD
baltimor	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	See /		22	2. Name	and Addres	s of Facilit	HOWE	CLL FU	JNEI	RAL HO	ME 21207
Ď	Depa Impo any ir		Plutun 19	1-0 Stu	14-	4	600	LIBE	ERTY	ĦĞŤŜ	SĀV,	BAI	RAL HO LTIMOR	Ē, MD
			23a. Paryl. Enter the disease, or com- shock, or hear value. List only	plications that caused one cause on each	the death.	Do not ent	er the m	ode of dying	g, such as	cardiac or	respiratory a	rest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition		C	se .			ner					Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequer		<i>J</i> -	- 0(:						
	Examiner		Cognostially list conditions	b										
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):								
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
00	be executed ician and burial-transit	Ě	resulting in death) cast	Due to (or as	a consequer	nce or):								
00/	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dlcal		d										
o X	ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	v							02d Data of da	lh and
X D D	attendation	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal de	ath 3	Ectopic Other (pregnancy					23d. Date of de Month	Day Year
j	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or deat	5	1 001101 (specify						
ŗ.	The law requires that the death certificate attending phys tate has been signed by the attending phys page 2 should be detached for use as the	, Ph	Part II. Other significant conditions c	ontributing to death be	ut not resultin	ng in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco i	use contribute t	o the cause of death?
ecords,	uires n sign ild be	d by									10	es 2	No 3□P	robably 4 Dunknown
Ö	w req	Completed									24a. Was		24b. Were a	utopsy findings available
Ė	Physician: The lav this certificate has ral director, page 2	dmo				***************************************					autor	rmed2	death?	completion of cause of
V IT ALL	in: T ificate or, pa	CC	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes Check only o	nel No	1 1 48	2 □ No
>	s cert	o B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 EB	VOutpatien	nt 3 🗆 I	Och Othe	26				6 ☐Other (Spe	ecify)
ō	a Phy erthi	n: T	27. Manner of Death	28a. Date of Injur	ry 28	3b. Time of		28c. Injury Work	at		d. Describe I			,
0	nding tth. r: Aft	atlo	Natural 5 Pending 2 Accident investigation		7 (Bal)	Injury	М	1	Yes 2□	No				
DIVISION	Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju-	ury - At home	e, farm, str	eet, fact	ory, office		28	f. Location (S City or Tov	Street ar	nd Number or R	ural Route Number,
5	s afte	Cert		bonding, die	3. (Opcony)									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical		ysician: To the best oniner: On the basis of	examination									
	thin the omple	Mec	29b. Signature and title of certifier	and manner sta	iteu.		2	9c. License	number			29d. Da	te signed (Mon	th, Day, Year)
	F 3 F 8	2	mal hand a	m				D .	108	54		i	19/200	
1	1.11		30. Name and address of person who	completed cause of d		За) (Туре,	Print)				1Himag			
2) '	10		32. 860istra	301 ar's Signatur		, P.	,1 Pin	4	15.	Aig w 14.16		21202	
	Sta Registr		31. Date filed (Month, Day, Year)	005 Deal	es. A	2 1	and A	1.0						

		State of Mary State of Mary State of Mary State Amend Item 1&Unpend Item 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of	Death	Reg	1. N6)	01878
Physici			Lyddane			Month	Day Year	1230 P M
/Medio Examin		4a. Facility Name (If not institution, give street and number) 300 CRUSADER ROAD		4b. CAMBR	Location of Dear		4,2005 ^{4°} DORCHEST	
Funeral Director			yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day, Y	9. Birthp Cour 7, 1961 Loui	place (State or Foreign
⊂ ≥		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or La	ocation		TOVALDEL I		Od. Inside City Limits
Mary I sh	to	Maryland Dorchester	Cambri					1 ☐ Yes 2 ☐ No
ith the Marylar or 28a-f show	lrec	10e. Street and Number	JOHN DE L	10f. Zip Code		10g	. Citizen of What Cour	ntry?
23a c	alD	300 Crusader Road, Apt. 101		2	1613	Un	ited State	s
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Heath and Mental Hygiene. It marked other then "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Examinar must be rectified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Ves 2 ☒ No 1 □ Ves 2 ☒ No 1 □ Yes Give Year or Dates:	1	Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
5-0 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation	16	b. Kind of Business/Inc	
Maryland 2121 12 should be filed within hand Mental Hygiene. 7 is marked other then "remedic event, Ire Med	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retired	during most of wo	rking	_	
d 2 filed v Hygie othar t	e Co	1 2 17. Father's Name (First, Middle, Last)	A	gent	18 Mother's Na	me (First, Middle, Ma	Insuranc	e
Maryland d 2 should be file th and Mental Hy ?? is marked oth traumatic avant	To Be	James F. Michie				nia Navarr	•	
ary shou		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street			ity or Town, State, Zip	Code)
re, M 1 and 2 Health tam 27 i		James F. Michie/Father	5407 (Glenwood	Road, Be		aryland 208	
0 00		'4 □ Donation 5 □ Other (Specify)	Ob. Place of Dispo- cemetery, crem Iontgomery C	Crematorium	Inc. 20	05 Be	c. Location - City or To thesda, Ma	ryland
Baltime permit. Pag Department Important: I any injury o		Us of all themshow	755)/ Wlsconsi	n Avenue, l	Sethesda, Mai	hesda-Chevy (cyland 20814-3	Chase, Inc. 3501
Pnysician /Medical	0.4	23a. Part1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Narcotic			g, such as cardiad	or respiratory arrest		Approximate Interval Between Onset and Death
Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of):					
the death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of deliver Month	y Day Year
S, F es tha igned be del	by P	Part II. Other significant conditions contributing to death but no	t resulting in the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	cause of death?
COTO A requir been s should	eted		<u> </u>			1 🗆 Yes	2 □ No 3 □ Proba	bly 4 Unknown
OVISION OT VITAI HECONGS, or Attanding Physician: The law requires that death. Director: After this certificate has been signe in by the funeral director, page 2 should be continued.	Completed					24a. Was an autopsy performed 1 Yes 2 □	prior to com death?	sy findings available pletion of cause of
OT VITA Physician: this certific ral director,	Ω.	25. Was case referred to medical examiner? Was 2 No	2 ER/Outpatient	Othe		th (Check only one)	- V	ATT. COTTO
SION OT tanding Phys leath. tor: After this the funeral di	atlon; To	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident vinvestigation 28a. Date of Injury For Matth, Day Yea	28h Time of	28c, Injury Work	at	ome 5 🔛 Residence 28d. Describe how in	o 6 X Other (Specity) njury occurred un	
ital or rs afte ral Dir.	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. (Sp. Scene	At home, farm, stre	eet, factory, office		28f. Location <i>(Street</i> City or Town, St 101 Cambri	and Number of Rural tate) 300°Crus dge, Md	ader Kd.Apı
hs Hosp n 24 hou ha Funa pletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death mination and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cause rred at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To t within To t		29b. Signature and title of certifier Pamelle & Southwell, MD			number .M.E		Date signed (Month, D AN. 25, 20	
		Name and address of person who completed cause of death			BAT.TTMORI	E, MARYLAND	21.201	
							21201	
Stat Registra	-	31. Date filed (Month, Day, Year) JAN 2 5 2005 32. Registrar's S					21201	

			1 - For State Registrar	State of Mai				Mental Hy		05 01879
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, La OROTHY 4a. Facility Name (If not institution, giv Northwest Hosp	OHLY e street and number)	r	4b. City, Town,	or Location of Dea	2. Date of Dea Month Januar th	Day 10 2 4c. County	Year 3. Time of Death 1858 p.M of Death altimore
	Funeral Director		5. Social Security Number 6. S 218–10–7205		(In yrs. last birthday)	If Under 1 Year Months Days				9. Birthplace (State or Foreign County) Maryland
	ith the Maryland or 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimor	re	Oc. City, Town or Lo	rstown 10f. Zip Code			10g. Citizen of W	10d. Inside City Limits 1 Yes 2 No
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any njury or other traumatic event, the Medical Examples I use the notified at once.	by Funeral	12601 Ivy N 11. Marital Status 1 □ Never Married 2 □ Married 3 文Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (Sban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	U.S. A 14. Race Black Specify:	- American Indian, c, White, etc.
Maryland 21215-0036	iled within 72 h Hygiene. ther than "netu nt, ihe Medica	Completed	15. Decedent's Ec (Specify only highest grave state on the state of th	College (1-4or 5+)	16a. Dece (Give life. HO1	dent's Usual Occu kind of work done DO NOT use retire	upation eduring most of wo		Homema	iker
ırylan	should be f nd Mental } marked of imatic eve	To Be	August M. So	hmitt	19b Mailir	on Address (Stree		ie Elizal	beth Gol	lery
	es 1 and 2 and 2 to Health and I item 27 is		Leslie Holman - 20a. Mgthod of Disposition	Daughter	12603 20b. Place of Disponsion Commetery, crem	Ivy Mil	Ll Rd., R	eisterst	own, Md.	21136 City or Town, State
Baltimore,	permit. Pages Department of i Importent: If its any njury or o		1	<i>'</i>)	Baltimor	e Cemete Name and Addr CKhardt	ery Jan.	Chapel, 1	P.A.	
	Physician /Medical Examiner	Examiner	23a Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	aDue to (or as a c	LDIOMYO consequence of):	er the mode of dy	ing, such as cardiac	or respiratory arm	wings Mi est,	Approximate Interval Between Onset and Death
.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/Medical Exa	resulting in death) Last	d. 23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim 9 Unknown	oregnancy	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery h Day Year
rds, P.	The law requires that the tile has been signed by the bage 2 should be detached.		Part II. Other significant conditions of CIROMC ORSTRUC			iderlying cause giv	-			ute to the cause of death?
al Record		Completed by		HYPERTEN!	SIOW			24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy findings available or to completion of cause of ath?
ion of Vital	ng Phys fter this neral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 [5]Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatient 28b. Time of Injury	28c. Injur Wor	ner: 4 Nursing H	th <i>(Check only one</i> ome 5 ☐ Reside 28d. Describe ho	nce 6 □Other	
Division	Hospital or Attendi 24 hours after death. Funerel Director: A stely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	building, etc. (5	Specify)			City or Town	, State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 2□ Medical Exam 29b. Signature and title of certifier	vician: To the best of miner: On the basis of example and manner stated	amination and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ite and place, an	d due to the cause(s)
)	0		▶ KRayfar	and M	(Itam 230) /Tuno 1	DS 4	4288	29	January (Month, Day, Year) Au 22 nd 205
	Sta	te -	30 Mane and address of person who company Wavy 31. Date filed (Month, Day, Year)	Day fa	Smature	North	ref Mod	licel co	rulg -	
	Registr		JAN	2 6 20 5	Eleva L	F Goore				

			1 - For State Registrar	State o	f Marylan			t of H	lealth a	and Me	ental Hy	giene Reg. No.2	05	018	80
	Physici	an	Decedent's Name (First, Middle							1	2. Date of Dea	ath Day	Year	3. Time of D	eath
	/Medio		Frances	Mary Ma	rsiglia		,				Januar		005	15:52	М
1	Examir	er	4a. Facility Name (If not institution		mber)				Location of				y of Death		
			207 Isinglass						Mills				imore		
	Funeral Director		5. Social Security Number 212-05-8807	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. I	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Birt (Month, Day May 15	h y, Year) , 1911	9. Birth	place (State or ntry)	Foreign
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	neation							10d. Inside City	Limita
	faryla sho	5		*										1 🗌 Yes	
	ath with the Marylan 123a or 28a-f show wat be redified at	Director	10e. Street and Number	imore	01	wings	10f. Zip	Code		-		10g. Citizen of	What Cou		_V
	with Sa or	ā		Dand			101. E.p							y.	
	ns 23	Funeral	207 Isinglass		edent Ever in U.	S. 13.	Was Deced	211 ent of Hi	ispanic Ori	gin? (Spec	ify Yes or No-		SA ce - Ameri	can Indian,	
10	fter dea	臣	1√2 Never Married 2 Marr	Armed Fo	rces?		If Yes, spec	rfy Cuba	n, Mexican	n, Puerto Ri	ican, etc.)		ick, White,		
93	urs a	by	A 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes If Yes, Giv Year or D	ve X ates:		1 ☐ Yes 2	No.	Specify:			Speci	^{fy:} Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ite Mudical Exeminer must be routified at	Completed	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usua kind of won	l Occupa	ation	t of working	,	16b. Kind of E	Business/In	dustry	
7	thin ear "	nple	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT us	e retired,) " " () () () () () () () () (t or working	,				
7	filed within Hygiene. other than	S	12	<u> </u>		Sa	les As	ssoç				Retail		es	
P	9 6 2 5	Be	17. Father's Name (First, Middle,									Maiden Suma	me)		
∑a		은	Harry Mars								Libert				
Maryland	Para a	0.0	19a. Informant's Name/Relations		. 37 • \							r, City or Town			
	is 1 and of Health item 27 other ti	1	Miss Trisha Sha	w (Great	-Niece)	20 / .	ISING	Lass	Road						
0	00-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from		lace of Dispo emetery, crei				Dai		20c. Location			
Baltimore,	ermit. Pag epartment nportant: I ny injury c	1	`4 □ Donation 5 □ Other (S)		Cre							Marriot			
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	2 Ha	ight	H.S.	AIGHT ykesvi	FUN 111e	ĒRĀĽ , MD	HOME 21784	& CHAP (410)	EL. PA -795-14	(Box	195)	
8760,	Physician / Medical Examiner and physician and physician and title private in the	icai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequence or as	TANDI uence of):								Approximate Interval Between Onset and De	ath
.O. Box 6	the death certifi y the attending sched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 tel No 9 ☐ Unknown	1 ☐ Live b	come of pregna irth 2 Tetal ant at time of de own	death 3[Ectopic pre						ate of delive	ery Day Ye	ar
rds, P	v requires that been signed t should be det	by	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the u	nderlying ca	iuse give	en in Part I.		23e. Did to	bacco use con		ne cause of dea	
Records,	he lav e has age 2	Completed				-					24a. Was a autop: perfor	med?	prior to con death?	psy findings av impletion of cau	ailable se of
Vital	sician: I certificat irector, pa	Φ	25. Was case referred medical						26. Place	of Death (Check only or			20110	
∠	d is	O B	examiner? 1 \sum Yes 2 \sum No	Hospital: 1 □ I	npatient 2	ER/Outpatier	nt 3 DO/	Othe	ar: 4 □ Nui	rsing Home	5 Sesid	ence 6 🗆 Oth	ner (Specif	y)	
n of			27. Mann of Death 1 ✓ Natural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o	f 28	Bc. Injury Work	at	28	d. Describe h	ow injury occur	red		
Ö	Attending r death. ector: After by the fune	atle	2 Accident investig	ation		,	М		Yes 2□1	No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	286. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory,	office		28	f. Location (S City or Tow	treet and Numi n, State)	oer or Rura	I Route Numbe	ır,
Q	ital c irs af ral Di	Cel		li li											
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the ba and man	best of my know asis of examinat her stated.	wledge, deati lion and/or in	h occurred a vestigation,	it the tim in my op	ne, date and pinion, deat	d place, and th occurred	d due to the o	ause(s) and make and place,	anner as st and due to	ated. the cause(s)	
	To t To t	Ž	29b. Signature and title of certifier						number			29d. Date signe		Day, Year)	
	11		1 Howa	nd Spl		_	6	2	879	2		1/24	DI		
1	21		30. Name and address of person	who c mpleted aus	e of death (Item	23a) (Type,						NGS in		WA 2.	111-
	Sta Registr		31. ate filed (Month, Pay, Year)	32 🛱	r's Signat				3 0.0	v ! -[1.007 1.0	1002	, 000	
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	Physici		1. Decedent's Name (First, Middle, Last) Teresa Faye Moore				2. Date of Deat Month JANUAR	Day Year	3.7 im of Dedit
	/Medio Examir		4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL			ORE CITY	OI HIGH	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 7. Age	o (In yrs. last birthda 54 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/14/1		thplace (State or Foreign ountry)
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	r 28a-f e	Director	Maryland 10e. Street and Number	Baltim	ore 10f. Zip Code		10	0g. Citizen of What C	1 XYes 2 No ountry?
	h witi	a D	812 North Bradford Street		2120	05		U.S.A.	
	deat	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 1		Hispanic Origin? (Spec an, Mexican, Puerto R	city Yes or No-	14. Race - Am Black, Whi	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any Injury or other traumatic event, the Medical Exertities must be notified at Once.	þ	1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced 1 Yes 2 Mr	lo	1 ☐ Yes 2 No	Specify:	iloan, oto.,	Specify: B1	
21215-0036	in 72 ho n "natur de ilical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dei (Gi life	cedent's Usual Occup ve kind of work done b. DO NOT use retire	oation during most of workin d)	g	16b. Kind of Business	/Industry
212	ylene r tha	E	Elementary/Secondary (0-12) College (1-4or 5	Nur	s e Assista	ant		Medical	
br	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Maiden Sumame)	
<u>yla</u> ı	Menta Menta arkad	T ₀	Freedom Wheatley			Hattie Ma			
Maryland	2 shc and Is m		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural			,
	l and fealth m 27 har tu		Kevin Evans / Son		North Brace Sposition (Name of	dford St.,		ore, Mary 1 20c. Location - City or	
Baltimore,	ges 1 nt of F if its or ot		20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, c	rematory or other pla	01/00/	2225		
華	nt. Partituder		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		n Cemetery	01/29/ pss of FacilityThe		andsdowne,	
Ba	Depared Important any Ir		The state of the s						land 21215
*			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not e					Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	a consequence of):	10 of	HEAD			
	D #	iner	cause. Enter Underlying	a consequence of):		-			
√(<u>1</u> ,	be executed ician and burial-transii	Examiner	Cause (Disease or injury that initiated events c	a consequence of):					
8760		dicai	d						
P.O. Box 687	To the Hospital or Attanding Physician: The law requires that the death certificate twithin 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
	quires that n signed b ald be deta	by	Part II. Other significant conditions contributing to death but	ut not resulting in the	underlying cause giv	ven in Part I.		acco use contribute to	o the cause of death?
Division of Vital Records,	The law recate has bee bage 2 short	Completed					24a. Was ar autopsy perform	prior to death?	utopsy findings available completion of cause of
'ita	stan: ertifica ctor, I	Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only one	e)	
) \	hysic his ce	은	1∆ Yes 2 No 1 Inpatie			4 Nuising nom		nce 6 Other (Spe	cify)
o uc	ling P	ion:	27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day	(Year) Injun	y Wor	ryat rk? Yes 2. StNo S	d. Describe ho	winjury occurred WAS SI	6T
ivisio	To the Hospitel or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the fu	Certification:	3 Suicide 4 SHomicide 3 Could not be determined 4 20 0 28e. Place of Injury building, etc.	iry - At home, farm, c. (Specify)	Street, factory, office	28	3f. Location (Str City or Town	reet and Number or R. , State)	ural Route Number,
	lospital in hours a unaral D		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of	of my knowledge, de examination and/or	ath occurred at the tir	me, date and place, ar	nd due to the ca	use(s) and manner a	saitmore, 70
	To tha h within 24 To tha F complete	Medical	29b. Signature and title of certifier	ted.	29c. Licens		29	od. Date signed (Mont	h, Day, Year)
	1		30. Name and address of person who completed cause of de	eath (Ite <i>m</i> 23a) (Typ	PENN STREE	T, BALTIMO	RE, MAR	YLAND 2120)1
	Sta	te.		r's Signature	He Aug	100 D			

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 01882 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, 2005 Florence Helen Manley January 2:05 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Months 1 □ M 20%F Aug. 31,1940 64 Maryland Director 214-38-4984 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts or 28a-f ehow itam 27 is markad othar than "natural", or itams 23a or 28a-f shov othar traumatic evant, the Mod raf Examiner must be notified at 1 Yes 2 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21222 United States 8255 Delhaven Road Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sparrows Point al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Server Country Club 9 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I ant: If itam 27 is markad o Marie J. Mohr Chester Piaskowski, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son 35915 Rhone Lane Winchester, CA 92596 Mr. Joseph Manley, III 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of important: if any injury or once. 1/22/2005 Baltimore, Maryland Oak Lawn Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee Dundalk, Maryland 7922 Wise Ave. art1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic cancer **Physician** months probable primary lung disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Unknown COPD Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No CRI 1 Tes 2 V No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a e Funaral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Tarimites m D047223 1-18-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Baltimore MD St 21204 Charles N egistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer **Physician** McCallus Lee Mary January 18,2005 8:07 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Co. Greater Baltimore Medical Ctr. Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2√□ F Yrs. Director 219-10-4917 26,1919 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medicul Examinar must be notified at 1 Yes 2 No Directo Nottingham Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 United States 6 Cameron Ct. Apt. G Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within. h and Mental Hygiene. 7 is markad other than " filed within Compi Elementary/Secondary (0-12) College (1-4or 5+) Salesperson 8 Years Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruth Dartnell Henry Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an 1005 Timber Trail Road Baltimore, Maryland 21286 Rev. Robert Harvey / Nephew 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 Burial 2 □Cremation 3 □Removal from State 4 Donation / Other (Specify) eadowridge Mem. Park 1/22/2005 Dorsey, Maryland Signatur of uneral SA 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prrysician PNEUMONIA DAU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISEASE RONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Tho 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X**No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 【▼ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 XNo completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pendina s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral L **X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number cyl JANUARY ZOGA ZOOS D0053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GURTA NO ELLICOTT CITY, 21042 6303 SUAKUNNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

				artment of Health and rtificate of Death	Mental Hygie	
Physicia /Medic		Decedent's Name (First, Middle, Last) Ling Fong Mou			2. Date of Death Month JAN 2	Day Year 3. Time of Death
Examino Funeral	er	4a. Facility Name (If not institution, give street at 5408 Bucksaw Court 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Deat Columbia If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	4c. County of Deeth Howard 9. Birthplace (State or Foreign
Director		N/A 1 □ M 24 Usuel Residence of Decedent 10a. State 10b. County	F 80 Yrs.		April 3,	1924 China 10d. Inside City Limits
th the Mary or 28e-f eho	Director	MD Howard 10e. Street and Number	Columbia	10f. Zip Code	10g	1 ☐ Yes 2 No Citizen of What Country?
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	ř	19a. Informant's Name/Relationship (Type, Prin Chun Lau Chau / Daugh	nter 540	g Address (Street and Number or Ru)8 Bucksaw Court,	Columbia,	
t. Partiment ritant;	9	20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Remova '4 ☐ Donation 5 ☐ Other (Specify) 21. Stornture > Funeral Service ticensee	Balt/Wash	natory or other place)	6/2005 I	aurel, Maryland
Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep		23a. Part1. Enter the disease, or complications shock, or heart tenure. List only one caus	76	601 Sandy Spring	Road, Laur	el, Maryland 20707
e be executed siscian and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of): ue to (or as a consequence of):	Carcliovascular	Discuse	Onset and Death Cars
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olcian: The law recentificate has be rector, page 2 sh	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
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To the Hospital within 24 hours a To the Funeral I completely filled	edicai	Check only S wedical Exeminer: On	To the best of my knowledge, death the basis of examination and/or inv I manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To To To To To To To To To To To To To T	2	296. Signature and vitte of certifier	MS	29c. License number D31473	1	Date signed (Month, Day, Year)
State Registra	-	30. Name and address if person who completed PATEVICE A. TOYE, A. 31. Date filed (Month, Day, Year)	d cause of death (Item 23a) (Type, F W 4565 He v 32. Registrar's Signature		Elliation	ity MV 21042

			State of Maryland / Department of Health and Certificate of Death		giene 005	01885
	Physicia		1. Decedent's Name (First, Middle, Last) CARL HUBERT MILLER	2. Date of Dea		3. Time of Death 2259 M
	/Medic Examin		SINAL HOSPITAL 4b. City, Town, or Location of Deat BALTIMORE	h	4c. County of D	eath
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 419-54. 6270 18 M 2 F 8 Yrs. Months Days Hours Min.			Birthplace (State or Foreign County) LABAMA
i	Maryland -f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
,	r 28a-f show	Director	MD N A BALTIMORE 10e. Street and Number 10f. Zip Code		10g. Citizen of What	1 ✓ Yes 2 ☐ No Country?
92L	th with	ral DI	1930 HARLEM AVENUE 21217		USA	merican Indian,
ک کی و	P 2 2	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer Organ or Dates:	to Rican, etc.)	Black, W	hite, etc.
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	re, Maryland ZIZIO-U- s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 is marked other than "natu	Completed	G TH GRAPE N A HANDY MAN			<u>nprovement</u>
ر د	laryland ∠ I ∠ 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be	17. Father's Name (First, Middle, Last) HERMAN WATSON 18. Mother's Nam MARY	me (First, Middle, MILLER		
	y, Warylan	·	19a. Informant's Name/Relationship (<i>Type, Print</i>) DERIC MILLER 19b. Mailing Address (<i>Street and Number or Right</i>) 227 EDGF WOOD ST.	ural Route Numbe	r, City or Town, State	e, Zip Code) 1 229
noven	altimore, mit. Pages 1 ar partment of Hea portant: If item y injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City	
\sim	Baltimore, Misperial Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tragones.		*4 Donation 5 Other (Specify) 21. Signature of Fugeral Service Licensee **A Donation 5 Other (Specify) **Property of Fugeral Service Licensee **A Donation 5 Other (Specify) **Property of Fugeral Service Licensee **Property of Fugeral Servic	TUNERAL	BALIO, M SERVICE	
72		1220	23a. Part1. Enlar he disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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	d f bU, cate be executed physician and the burial-transit	cal	Due o (or as a consequence of): d. Carelio-11/0 Petty			
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	On Of V Jing Physic After this ce tuneral dire	o L	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (S	Specify)
:	ISION ttendin death. ctor: Aft y the fun	Certification;	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office	28f. Location (S	Street and Number or	Rural Route Number,
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	the Hosi in 24 ho the Fund ppletely f	ledical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and or other and the basis of examiners and the basis of	urred at the time,	date and place, and	due to the cause(s)
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	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	G Al	celence?.	(e, LED 2/22)
	Sta Regist		31. Date filed (Month, Day Year) 2005 33 Segistrar's Signarie	7 7	10,07/	

Registrar

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31. Date filed (Month, Day, Year)

JAN 2 6 2005

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1_ For State		land / Dep	artment of Hea	alth and M	ental Hygie	ene	
		-	1 - State Registrar 1. Decedent's Name (First, Middle, Las	*1	Ce	rtificate of De	eath		. Ng. 0 5	01887
	Physic		Carmen A. Milan	i)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Loc	cation of Death	January	23, 2005 4c. County of Dear	11:05A M
			9404 Garden Cour	t		Potomac			Montgome	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year If Months Days H	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign ountry)	
	Director		355-26-8920 Usual Residence of Decedent	1W 2 2 3 F	88 Yrs.		lours Min.	July 18,	1916 Phi	lippines
	yland 10w		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	tor	Maryland Montgomer	rv 1	Potomac					1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	ath w	rail	9404 Garden Cour			20854		Un	ited Stat	es
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe fexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
920	urs at	þ	3 Widowed 4 □Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1□Yes 2፟MiNo <i>S</i> p	pecify:		Specify:	
Maryland 21215-0036	be tiled within 72 hours after death with the Maryland nat Hygiene. So of ther than "natural", or tems 23a or 28a-f show event, the Medical Exercise are rural to notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupation)	168	A So. Kind of Business/	ian Industry
21	within lene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done durin DO NOT use retired)	ig most of workin	ng		
2	e tiled w Il Hygier other ti vent, Ib		17. Father's Name (First, Middle, Last)	5+	Ph	narmacist			ospital P	harmacy
and	ild be t lental h ked of ic ever	Be						(First, Middle, Mai	den Sumame)	
7	2 should be and Mental is marked (P	Teodora Acosta 19a. Informant's Name/Relationship (T	voe. Print)	19h Mailir	ng Address (Street and I	Estefani Number or Rural	a Lopez	itu or Tourn State 3	To Code)
	다 등 등 다		Cynthia Lieberman			Garden Cou				854
Baltimore,	ot Heal		20a. Method of Disposition	2	Ob. Place of Dispo		Janua		Location - City or	
ij	permit. Pages 'Department of H Important: If ite any injury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	. 1	lontgomer Crematori	V	2005	•	ethesda, 1	Marvland
alt	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	99	22	. Name and Address of	Facility Robe	rt A. Pu	mphrey Fu	neral Home/
ш_	20 E 20		1 KA Wh		353 Be	thesda, Mar	vy Chase ryland	20814-35	05/ Wisco	nsin Avenue
	Physician		23a. Part I. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.				respiratory arrest,		Approximate Interval Betwe <i>e</i> n Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co		Heart failu	ıre			
и	Examiner		Sequentially list conditions.	b. Hypertens						
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
	death certificate be executed e attending physician and id for use as the bunal-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	siciar buria	ical E		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
89	g phy as the	edic								
Вох	eath certitic attending p	Physician/Med	200. Was acobacili program	.3c. If yes, outcome of pr 1☐Live birth 2☐		Ectopic pregnancy			23d. Date of delin	very
П	e dea he att	sicia	in the past 12 months? 1 🗆 Yes 2 🔯 No	4☐Pregnant at time		Other (specify)			Month	Day Year
<u>О</u>	d by the detetached	Phy	9 Unknown							
ds,	Attending Physician: The law requires that the redeath redeath. sctor: After this certilicate has been signed by the storic After this certilicate has been signed by the year the tuneral director, page 2 should be detached.	by	Part II. Other significant conditions con Paralysis Agitan		t resulting in the ur	iderlying cause given in	Part I.		o use contribute to	
Sor	w require been sig should b	etec	Cachexia		-				2 X NO 3 P P O	bably 4 Unknown
Records,	he lav e has ige 2	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ta	ysician: The is certiticate hadirector, page	Be Co	Dementia 25. Was case referred to medical				Discoul Devil	1 Yes 2X		2 □ No
<u> </u>	ysici is cer direct	0	examiner?	lospital:	2 ☐ ER/Outpatient			(Check only one)	6 □Other (Speci	6()
0	ding Phy h. After thi tuneral o	T iuc	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea		28c. Injury at Work?		d. Describe how in		197
Sio	r Attendii er death. rector: A by the tu	catio	2 Accident investigation 3 Suicide 6 Could not be		, , , , , ,	M 1 ☐ Yes	2 🗆 No			
É	in Sire	Certification;	4 Homicide determined	28e. Pface of Injury - building, etc. (S)	At home, farm, stre	eet, factory, office	28	If. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely tilled in by the		29a. Certifier 1X Certifying Phys	zician: To the heat of	knowledge day'	and the second s	to and the			
		Medical	(Check only 2 Medical Examinations)	sician: To the best of my ner: On the basis of exar and manner stated.	mination and/or inv	estigation, in my opinion	ate and place, an n, death occurred	d due to the cause I at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	To the Hospital within 24 hours a To the Funeral completely tilled	Me	29b. Signature and title of certifier	*		29c. License num	nber	29d. [Date signed (Month,	Day, Year)
)	111		Wiggea	me,	4. W	D21662		Ia	nuary 24,	2005
14	5		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, F			Ja	muary 24,	2000
Į,	V		Wilhelmina G. Ca	mina, M.D.	4912 Adı	rian Street	, Rockvi	ille, Mar	yland 208	53
	Stat Registra	te ar	31. Date filed (Months Any 2") 6 2	32. Refistrar's S	ignature	harts a				
10	alati			1	- ~	The same of the sa				

000006 05-00606 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. d1For Unpend Item 23a, 27, 28a Per meres of Death Registrar Certificate of Death JAMES MORGAN 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Morgan January 2005 2:03 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner across from 1900 Old Eastern Ave. Essex Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months Days Hours Min. | Sept. 23, 1955 | Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 219 70 2036 49 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "naturel", or Items 23e or 28e-f show the Madical Examiner must be notified at Maryland Baltimore 1 Yes ZX No Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 Homberg Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 10 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental I Robert James Morgan Ida M. Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 Is or other tre Sharon Schmidt (Sister) 3701 Red Grove Rd. Baltimore, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of h 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Holly Hill Mem. Gardens 1/28/2005 Baltimore, Md. ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²². Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Drukouske 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by ck, or heart failure. List only one cause on each line.

Immediate Cause (Final Complications Of Chronic Alcohol Abuse Complicated By Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypothermia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physiciar Completed by Physician/Medical as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1

✓ Yes 2

No 24a. Was an autopsy performed? certificate 2 No 1 Yes Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Xes 2 No 28a. Date of Injury (Month, Day Year) FOUTD 244-2005 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Found 1:45 P 1 Natural 5 Pending after death. 2 XAccident investigation Subject Exposed To Cold 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1900 Old Eastern Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Thomicide Scene Essex,_Md within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signa

t-Southell, MD

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

JAN 2 6 2005

Pamela



OCME

January 25, 2005

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #2 PER DVR G839 1 PET V 15 Sate Appl Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 ^{Day} 23, **Physician** Glenda Nea JANUARY 9:30A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST REGIONAL HOSPITAL RANALLSTOWN BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F 219.56.5257 53 Yrs. Director MD 09.02 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 23e or 28e-f ahow 10d. Inside City Limits Baltimore MD Be Completed by Funeral Director GWYNN Dak 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 DUKE of USA Windsor Ct. # 103 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō of Health and Mental Hyglene.
f item 27 is marked other then "natural", or
ir other traumatic event, the Modisol Exami 1 ☐ Yes 2 X No Specify: BLACK 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Citu 1 and 2 should be filed within Health and Mental Hyglene. am 27 is marked othar then Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) Para Professional Schools ZVEARS 18. Mother's Name (First, Middle, Maiden Sumame) W. Hams UINSSES Malinda ၉ Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD Desmond Neal 2114 Park Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any injury or once. 01.29.05 WOODLAWN, MD ⁴ □ Donation 5 □ Other (Specify) WOODLAWN 21. Signature of Fur and Service Licens 22. Name and Address of Facility
Vaughn C: Greene Funeral Services
5151 Partimore National Pike Baltimore MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hyportensive atherosclerotic cardiovascular disease Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Munknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 2 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

And manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w, O.C.M.E. JANUARY 24,2005 miD 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 PENN STREET BALTIMORE, MARYLAND 21201 LI MID ogistrar's Signature 31. Date filed (Month Pay, 2ºar 6 2005 State Registrar

VOID

CERTIFICATE

2005 - 01890

SEE

CERTIFICATE #

2005-02947

		Í	For State Registrar	State of	Marylan	•	artment of H		d Mental Hy	ygiene Reg. No.	2005	01891
	Physicia	ın	1. Decedent's Name (First, Middle, L		-aon				2. Date of D Month	Day		3. Time of Death
	/Medic	al	Jacqueline Franc				4b. City, Town, o	r Location of Do	ath /	21	2005 County of Death	
	Examin	er	4a. Facility Name (If not institution, gi	1.1	1 1		Rosed	ale	dili		altim	
	Funeral		5. Social Security Number 6.		ax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.				rs. 8. Date of B	irth	9. Birthplace (State or Country)	
	Director		216 52 3446	1□M 2XF	55	Yrs.	Months Days	Hours M	in. 8. Date of B (Month, D Dec. 14	, 1949	Mary	zland
01	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
2	f sho	0	Maryland Baltimo	ore		Midd	le River					1 ☐ Yes 2 1 No
Di Kupa	the 7	rect	10e. Street and Number				10f. Zîp Code			10g. Citiz	zen of What Cou	intry?
0)	th with	aiD	511 Nollmeyer Ro	1.			212	220			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumetic event. In Medical Examination must be routified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Zipivorced	12. Was Decedd Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⊠ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.
500	72 ho natur ilical	eted	15. Decedent's I	Education rade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	vorking	16b. Kir	nd of Business/li	ndustry
72	within Ne.	Completed by	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use retired Cook	d)		Pos	staurant	_
- 2	be filed v stal Hygie ed other t event, In		10 17. Father's Name (First, Middle, Las	;t)		<u> </u>	COX.	18. Mother's N	lame (First, Middl			,
ano	Mental Merked o	To Be	James Louis Rybak					Doris	Brannar	1		
Maryland Maryland	should and Men s marke umetic	۲	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or	Rural Route Num	ber, City or	Town, State, Zi	ip Code)
E S	and 2 salth a n 27 is		Doris Goldberg (S	Sister)		_	Nollmeyer	Rd. Ba		_		
Nicke Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from St	ate	emetery, cre	osition (Name of matory or other plac		Date		cation - City or T	
JE	rent of trent of trut: If it		' 4 ☐ Donation 5 ☐ Other (Spec	eify)	Bay		Crematory		2/2005			Maryland
Bai	permit. Depart Import any inj.		21. Signature of Funeral Service Lice	Burkoe	uske		Name and Addre Bruzdzins 1407 Old	Eastern	Avenue	Essex	K, Ma. 2	1221
			23a. Part . Enter the disease, or contho k, or heart failure. List on	mplications that cau y one cause on eac	sed the deat th line.	h. Do not en	ter the mode of dyin	ng, such as card	liac or respiratory	arrest,	DATE:	Approximate Interval Between Onset and Death
١	Physician		Imm ' te Cause (Final disease or condition resulting in death)	= a. Acit	e re	spir	atory	distres	SS 5411	drom	ie	Onset and Douth
	/Medical Examiner		resulting in death)	0	as a conseq	uence of):	0		J			
		-	Sequentially list conditions,	V	Se a coursed							
X	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								1	
ó	rate be executed thysician and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):						
8760	ate be nysicia he bu	lical		d								
	entifica ling ph e as t	Med	IF FEMALE:	OZa If was auton	ma of program						D 1 D 1 1 1 E	
Division of Vital Records, P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ☐ Feta nt at time of d	I death 3[Ectopic pregnancy Other (specify)	/		2	3d. Date of delive Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	inderlying cause giv	en in Part I.			se contribute to □No 3□Pro	the cause of death?
l Reco	icien: The law requ certificate has been rector, page 2 should	Completed	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `						24a. Wa auto per 1 \(\text{Yes}	s an opsy formed? 2 X No	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital: V.			Oth	an.	eath (Check only			
of	Phys this cral dir	<u>۲</u>	1 Yes 2 No 27. Magner of Death	JA lub		ER/Outpatie	III 3 LI DOA	4 🗆 Nursing	Home 5 Res			(fy)
on	ding th. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of (Month, on	Day Year)	Injury	Wor	k? Yes 2 □ No		,		
Divisi	To the Hospitel or Attending Physicien: The within 24 hours after death, To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide 6 Could not determine	h.	f Injury - At he j, etc. <i>(Specif</i>	ome, farm, st	reet, factory, office			(Street and own, State)		ral Route Number,
	To the Hospitel within 24 hours To the Funerel completely filled	edical (29a. Certifier (Check only one) 17 Sertifying F	Physician: To the baminer: On the bas and manne	is of examina	owledge, deal ation and/or in	h occurred at the tire vestigation, in my o	me, date and pla pinion, death or	ace, and due to the courred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the within	¥	29b. Signature and title of certifier Jump	t Supto	, m	0	29c. Licens	se number	0	29d. Date	3 signed (Month)	Day, Year)
	2		30. Name and address of person wh	o completed cause	of death (Item			n	11'	.11	0 010	~ ~
			Dr. Summit Gupt	-C, 700 h	ran Kl gistrar's Signa	IN DO	uare Dri	VR, BO	Itimore	, 1'(1 212	3 /
	s Sta Registr	•	JAN 2 6 20	#	a. 1.	Soo	de la					
DH	IMH 17 Rev 1/20	001				3						

State of Maryland / Department of Health and Mental Hygiene 0 05 1 - For State Registrar 01892 Certificate of Death 1. Decedent's Name (First, Middle, Last)
Earl Roy Ostr 2. Date of Death 3. Time of Death January 23 Jr. **Physician** Ostrander 2005 7:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Finksburg 2600 Jeffery Lori Drive Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) April 14 1927 Birthplace (State or Foreign Country)
 Md Funeral 1**∑**M 2□F Months Days Hours 216-20-4519 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or Items 23e or 28e-1 show ury or other treumatic event, It a Mardial Examiner manale multill, die Md Carroll Finksburg Funeral Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2600 Jeffery Lori Drive 21048 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No ρ Specify: Specify: white 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) computer technology computer repairman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earl Roy Ostrander Sr. Helen Gray Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Helen Mancha (daughter) 2600 Jeffery Lori Dr., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 1-27-05 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asthma /Medical Due to (or as a consequence of): Examiner ship teast orifolia Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physicien: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 10 2 ER/Outpatient 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year 1-24-2004 51705 30. Name and address of person who complet d cause of death (Item 23a) (Type, Print) Hestminston, mp 21157 DR, 349 PANSURIVA modrom 31. Date filed (Month, Day, Year) 32. Radistrar's Signature State 2005 Registra

DHMH 17 Rev 1/2001

ORIGIÑAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deatl Year **Physician** VEDA GENEVIE OLSHEFSKI 02:45 MUMPY 2005 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VISTA MOBILE DRIVE DUNDALK Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 1 X E 9,1931 Auq. Director 73 235-46-4506 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rsi', or items 23a or 28a-f shov Examiner must be notified at Dundalk 1 ☐ Yes 200No Baltimore Maryland Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with United States 21222 4 Vista Möbile Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: 2 White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Management 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Blair Jasper Reidy Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3415 Dunran Road Dundalk, Maryland Mr. Shawn L. Olshefski/Son Department of Haalth Important: if Item 27 [20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Important: If It any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 1/17/2005 Baltimore, Maryland □ Donation 5 □ Other (Specify) ure of Funeral Service Liperisee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical immediate Cause (Final & CHRONIC OBSTRUCTIVE PULMONARY DISEASE YRS disease or condition resulting in death) Examiner Due to (or es a consequence ol) Examiner physicien end the buriel-transit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): ettending p 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown OSTEOPOROSIS ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? s cartificate has bodirector, page 2 s TLL Yes 20000 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) CS IDENCE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.

I Director: Af
id in by the fu 2 🗆 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 I Homicide within 24 hours a
To the Funeral C
completaly filled Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (29a. Certifier To the 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License numbe MD 2005 D0062032

Registrar

505 HOPKINS BAYVIEW CIRCLE, BALTIMORE MD 21224

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

HAYASHI, MD

31. Date filed (Month, Day, Yeer)
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			1 - For State Registrar	State of	Marylar		artmen rtificate				lental Hyg	iene	005	018	394
	Physic	ian	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	th		3. Time <i>o</i>	f Death
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7	Exami	ner	4a. Facility Name (If not institution, ga	ve street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. Co	ounty of Death	<u> </u>	
			Holy Cross Hosp						Sprin	_		Mo	ontgome	ry	
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21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Francia or must be notified at	Completed by	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced	lent's Usual kind of worl	Occupa k done d	tion urina most	of worki	na	6b. Kind	of Business/Ind		
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9 X	eath certific attending p	/Me	IF FEMALE:	220 Have entrem	(
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3 □E	Ectopic preg					23d.	Date of deliver	,	
o.	the d	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown	at time of de	ath 5∐	Other (spec	cify)					MOILLI	Day Y	ear
صّ	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	y Ph	Part II. Other significant conditions of	ontributing to death	but not resu	Iting in the und	derlying cau	se given	in Part I.		23e. Did toba	CCO USA C	ontribute to the	A CRUSO of do	anth?
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/	(7)		30. Name and address of person who	completed cause of	death (Item :	23a) (Type, Pr	rint)	20	10	Con	e the	11-		MAG	
	Stat	ó	31. Date filed (Month, Day, Year)	TWIT 2	par's Signatu	100	10	78	14	JU	ethe	250	nerg	11/1	3-
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JANUARY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** -3572 1□ M 2♥F Months Mary Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1 Yes 2 No NA MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 5 atherine 103 Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: if item 27 is marked other than "natural", or ite may injury or other traumatic event, the Wedigal Exportance. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ₽ 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Uperator lath 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Mighele, Last) Mary Albert Coston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S. 103 Balto. 55a daughter Catherine 21223 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lom. ' 4 ☐ Donation 5 ☐ Other (Specify) DLANN 21. Signature of uneral Service Livensee 22. Name and Address of Facility P. March Fly 270 Fredhilton Riss Ballo. Mo 21229 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Z DAYS /Medical Due to (or as a consequence of): Examiner MULTIORGAN 2 DAYS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine igned by the attending physician and be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 Yes 2 10 No Month Year Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Ves 2 No Hospital or Attending Physician: 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 0 No 1 // Inpatient 2 2 ER/Outpatient 3 DOA 27. Mann of Death Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Chack only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number January 16, 2005 umo, MO AT 2438946 19 completed cause of death (Item 23a) (Type, Print) ndrimo, M.D. 201 E. University Parkway 32. Bigistrar's Signature 31. Date filed (Month, Day, Year) JAN 2 6 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Vera Irene Peters January 24, 2005 7:27am /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 14000 Castlebar Drive Glenwood Howard If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□ M 2□ F Months Deys Yrs. 492-07-7052 96 MO Nov. 9. Usuel Residence of Decedent 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Vernon Nevada 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 346 64772 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: \$ 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Telephone 12 Operator 4 8 1 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) J0hn Johnson Gertrude Allred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Robin Vance (Cousin) 14000 Castlebar Drive Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State 1. 19:05 Nevada, Missouri 4 ☐ Donation 5 ☐ Other (Specify) Newton Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that laused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death a. LYMPHOMA

Due to (or as a consequence of):

DUE TO CONGESTIVE HEART FAILURE Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SENELITY 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Š 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 463 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Kelatures Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 7 NO 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

ettending physician end I for use es the bunel-trensIt Division of Vital Records, P.O. Box 68760, or Attending Physician: deeth.

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours efter of Hygiene. Wher than "natural", or item

permit. Peges 1 and 2 should be Depertment of Health and Mentel mportant: If Item 27 is marked or

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best or my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

4 Homicide

(Check only one)

29a. Certifier

29c. License number D0050870

29d. Date signed (Month, Day, Year) 1/24/05

30. Name end address of person who completed cause of deeth (tem 23e) (Type, Print) Sell in Clarify MD 2029 31. Dete filed (Month, Day,

State Registra

32. Restrar's Signature Elsen B. Agood 2005

within 24 hours of To the Funeral I

Medical

			For State Registrar			Maryland		rtment tificate					Reg. No.	2005	0189
	Physici	an	1. Decedent's Name (F	_) ETER	CaN					-	2. Date of De Month	Day	Year 2005	3. Time of Death S. U.C. A.M.
	/Medic Examin		4a. Facility Name (If no HOWARD C	ot institution, give	street and numb				Town, or UMBI	Location of	of Death	JAN		ounty of Death WARD	12,43
	Funeral Director		5. Social Security Num 517-12-8576	15	x 7. ⊋M 2□F	Age (In yrs. Ia 90	st birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Bir (Month, Da IULY 13	ıy, Year)	9. Birth	place (State or Foreign Intry) MONTANA
	Maryland a-f show	tor		Ob. County			Town or Lo		Y						10d. Inside City Limits 1 ☐ Yes 2 X No
	with the a or 28.	Direc	10e. Street and Number 4055 ARJA		Ξ			10f. Zip						of What Cou	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show emportent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show empiringly or other treumatic event, I'm Medical Eracin at most be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	12. Was Deced Armed Forc 1 7 Yes 2 If Yes, Give Year or Date	es? No				spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	city Yes or No Rican, etc.)	14.	S.A. Race - Americ Black, White,	
21215-0036	od within 72 ho giene. er then "netur	Completed	15 (Specify Elementary/Seconda	5. Decedent's Edu only highest grad ary (0-12)	cation de com <i>pleted)</i> College (1-4	or 5+)	life. L	lent's Usual kind of work OO NOT use MY OF	k done d e retired)	u <i>ring</i> most	of workin	ng .		of Business/In	dustry JS ARMY)
Maryland	should be filed ind Mental Hygie a marked other umatic event, II	To Be (17. Father's Name (Fir. PETER G.		ON							(First, Middle SVENSO		mame)	
Mar	and 2 sho salth and n 27 is ma		19a. Informant's Name					g Address ARJA					-	own, State, Zip MD 210	
lore,	Pages 1 and the south of the so		20a. Method of Dispos	ition Cremation 3 🔲	Removal from St	ate cei	nce of Dispo metery, cren	natory or oti	her place	1		ate		ion - City or To	
Baltimore,	permit. Pa Departmen Importent: eny injury		*4 □Donation 5 [21. Signature Funer			ARL]	1	. Name and	Addres	s of Facility	FLEC	K FUNE	RAL H	LINGTON OME,INC D 20707	
	Physician		23a. Part1. Enter the shock, or heart to shock, or heart to shock and the shock or condition resulting in death)		lications that cause on each	1	Do not ente	er the mode	of dying	em	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			tions	Due to (or	as a conseque	ence of):								
8760,	icate be executed physician and s the burial-transit	al Examiner	Sequentially list condit if any, leading to infine cause. Enter Underlyi Cause (Disease or inju- that initiated events resulting in death) Las		c.	as a conseque									
O. Box 6	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent print the past 12 months of 1 Yes 2 N 9 Unknown	onths?		h 2∏Fetalo nt at time of dea	death 3	Ectopic pre					23d	. Date of delive	ery Day Year
Δ.	quires that the de n signed by the a uld be detached f	by	Part II. Other significa	nt conditions co	entributing to dea	th but not resul	ting in the ur	nderlying ca	use give	n in Part I.			obacco use Yes 2 1 N		he cause of death?
I Records,		Completed										24a. Was autor perfo		prior to co death?	opsy findings available impletion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:				Othe	-		(Check only o			
of	iing Phys n. After this funeral dii	atlon: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of (Month,		R/Outpatien 28b. Time of Injury		c. Injury Work	4 1140	2	ne 5 Resident		Other (Specificcurred	5y)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:		6 Could not be determined	286. Place of	f Injury - At hon , etc. <i>(Specify)</i>	ne, farm, stre	eet, factory,	office		2	8f. Location (City or To		lumber or Rura	al Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical ((Chack only of	Z¹Certifying Phy ☐ Medical Exam	inon On the hea	in of avamination	on and/as inc	anding ston		inion done	b	al as show since	alaba aaal ala		- Ab / - \
	To th within To th comp	Me	29b. Agnature and title	e of certifier				29c.	License	number			29d. Date s	igned (Month,	Day, Year)
	141		20 Nome and of the	of parent into	omoleted cours	of death (lease)	220) /7:	Print'	143	720			11	241	9031221
	, ,		30. Name and address	On Vers'	7 Hm	O O O	201-1	09	Bo	ick	Riv	er No	ckr	Ld B	Day, Year) OS Colhimore
	Sta Registr		31. Date filed (Month,	JAN 2 6	2005 D	Males Signatu	J.	Soul	1						

			1 - State Registrar	te of Maryland		rtment of F		-	giene20	05 01898
	Physici	an	Decedent's Name (First, Middle, Last)	a a				2. Date of De Month	ath Day Y	3. Time of Death
	/Medic	al	Shantaben 4a. Fecility Name (If not institution, give street a		atel	4b. City. Town. o	r Location of Death	Janus	4c. County of	2005 62:00 ^{AM}
	Funeral Director	er	5. Social Security Number 6. Sex 215-08-3545	1 medical 7. Age (In yrs. Ias	Center st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Dec. 1	N _I	9. Birthplace (State or Foreign Country) India
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Maryl s-f sho	tor	Maryland Howard	Cla:	rksvil	1e				1 ☐ Yes 2 🛣 No
	ith with the 23a or 28i ust be not	Funeral Director	10e. Street and Number 6541 Limerick Court			10f. Zip Code 21029			10g. Citizen of Wh India	at Country?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examinar must be notified at once.	Þ	1 Never Married 2 XMarried 1 If Y	s Decedent Ever in U.S. ned Forces? Yes 2X No es, Give ar or Dates:		as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No Rican, etc.)		American Indian, White, etc. Asian Indian
1215-0	within 72 h	Completed			(Give k. life. Di	O NOT use retired	during most of working	ng	16b. Kind of Busin	
Maryland 21215-0036	uld be filed Aental Hygie rked other tic event, u	To Be Co	6th Grade 17. Father's Name (First, Middle, Last) Amichanddas J. Patel		Homen	laker	18. Mother's Name			ie
	and 2 sho ealth and I n 27 is ma		19a. Informant's Name/Relationship (Type, Pri. Ratilal S. Patel - So	n	6541 I	imerick	and Number or Rura Court, C1	larksvi	11e, MD.	21029
altimore,	ages 1 nt of He : if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	from State	netery, crema	ition (Name of atory or other place	ce)	ate	20c. Location - Ci	
altin	mit. Parantmer sortent rinjury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	part	-	sh. Crem. Name and Addre			Laurel, M eral Home	
<u>~</u>	Depa Impo any ir		Jan 19	M0086			y Spring I	Road, L	aurel, MI	
	Pnysician /Medical		234. Part1. Enter the disease, or complication shock, or heat failure. List only one cads Immediate Cause (Final disease or condition resulting in death)	that caused the death. e on each line. Colitis		r the mode of dyin	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death S days
8760,	physician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	2	twb/	noma				7 months
.O. Box 6	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/Med	in the past 12 months?	es, outcome of pregnance Live birth 2 Fetal de Pregnant at time of deat Unknown	eath 3□E	Ectopic pregnancy Other (specify)	,		23d. Date of Month	,
٥.	res that igned b be deta	by	Part II. Other significant conditions contributing		ing in the unc	derlying cause giv	en in Part I.			ute to the cause of death?
Records,	w raquir baan s should	eted	Hypertension, Di	abetes				1 🗆 Y		☐ Probably 4 ☐ Unknown re autopsy findings available
	iician: The lav certificate has rector, page 2	Completed						autop	sy prio med2 dea	or to completion of cause of the the
Viital	ician: certific ector,	Be	25. Was case referred to medical examiner?			3C DOA Oth	26. Place of Death			
Division of	Phys this al di	atlon; To	1 165 2 140	1 € Inpatient 2 LEF	8b. Time of Injury	28c. Injun World	4 🗆 Mursing Hon		lence 6 Other ((Specify)
Divis	Hospital or Attending I 24 hours after death. Funeral Director: After tely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home building, etc. (Specify)	e, larm, stree	et, factory, office	2	28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitai or A within 24 hours after To the Funerai Directompletely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medicel Exeminer: Or an	To the best of my knowle the basis of examination manner stated.	edge, death on and/or inve	occurred at the tine estigation, in my o	ne, date and place, a pinion, death occurre	and due to the ded at the time, o	cause(s) and mannedate and place, and	er as stated. I due to the cause(s)
	To the To the comp	W	29b. Signature and title ol certifier			29c. License			29d. Date signed (A	
,	7		30. Name and address of person who complete	mD PhT d cause of death (Item 2		_	8561		Januar	1 26, 2005
			Pinaki Dutta, 25	South G	reene	_	ultimore,	mp	21201	
	Sta Registr	-	JAN 2 6 200	32. Hegistrar's Signatur	(e)		,			
DHI	MH 17 Rev 1/2	-60	Onit & U ZUUT	110,500.00	RIGINA	poli				
				U	THORNA	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 Month **Physician** AUDIE PEACOCK 2005 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES TAL

RACTIMORE

7. Age (In yrs. last birthday)

Wonths Days Hours Min. NIA HOSPITAL 5. Social Security Number 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 6. Sex Year) **Funeral** 1**⊠**M 2□ F 242-16-5581 87 Yrs. NC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b Counts 10a State or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.
and it if item 27 is marked other then "naturel", or items 23e or 28e-f show and it is Medical Examination and the maillified at any or other traumatic event, it is Medical Examination and the maillified at Baitimore Baltimore 1 ☐ Yes 2 No MD Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 Cooks Lane UDB 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 ☐ No If Yes. Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: BLACK 3 5€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Mechanic 8th grade NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mollie Williams John Peacock 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9807 Middle Mill Drive Dwinas Mills MD 21117 Clande Peacock Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Baltimore, MD 1 Burial 2 Cremation 3 Removal from State Depertment of important: If eny injury or once. 01.27.05 Baltimore Nat'l * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Vanghin C. Greene Funeraj Services 5/5/Baltimore National Pike Baltimore MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiovascular Atherosolplatin 18a13 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably

Year

4 MUnknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

plan

24a. Was an autopsy performed? 1 ☐ Yes 2 D No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death Natural 2 Accident

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

■ ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Completed by

Be

2

Certification:

Medical

certificate

After

Director:

within 24 hours a
To the Funeral C

To the Hospital or Attending Physician:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Laton

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Physician Attendina address of person who completed cause of death (Item 23a) (Type, Print) Silverman Michae

31. Date filed (Month, Day, Year) 2005

900 32. Registrar's Signature الكر منطاع

Registrar

LO	LI			State of M							-		_	ne.	
			1 - Stata Registrar			-	tificat				-	Reg. N	2111	5	01900
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of De Januar		¥, 20	¥9 4	3. Time of Death 7:00 P. M
	/Medio	al	Blakley Eva		r)		4b. City,	Town, or	Location of	of Death			. County		7.00 1
	LXamii		3110 Roop Road		_		Tane							crol]	L County
	Funeral Director		5. Social Security Number 6. Sec. 212–72–5502	7. A	47	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept 1	th 19, Year, 5, 1	957	9. Birthp Cour MD	place (State or Foreign ntry)
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits
	he Man 8a-f sh culfied	Director	MD Carro				101 7		neyto	own		40- 0			1 ☐ Yes 2 🛣 No
	with t	늅	10e. Street and Number 3110 Roop Road				10f. Zip	1787				10g. Ci	tizen of W USA	nat Cour	ntry?
	death	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.	.S. 13. V				gin? (Spe	ecify Yes or No Rican, etc.)	- 1	14. Race		an Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or itams 23a or 28a-f show event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 If Yes, Give Year or Dates	XNo		l ☐ Yes		Specity:	i, Fueito	riicaii, eic.)		Specify:	k, White, Wh	ite
Maryland 21215-0036	72 ho 'natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	lent's Usua kind of woi	I Occupa rk done d	ition luring mos	t of worki	ng	16b. K	Cind of Bus	siness/Ind	dustry
121	filed withIn 72 Hygiene. other than "nat	dmo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		ро мотия k Dri			remar		Tra	nspo	rtat	ion/Fire
מ	be filed ital Hygi id other evant, I	Be Co	17. Father's Name (First, Middle, Last)			1140	L DII	1	•		(First, Middle,	Maider	Sumame)	
ylai		ToE	Unknown							Phy11			Baug		
Mar	S S S S		19a Informant's Name/Relationship (7 Mrs. Lisa Nastri								n, GA			State, Zip	Code)
re,	is 1 and 2 of Health itam 27 other tru		20a. Method of Disposition		20b. F	Place of Disposemetery, crem					ate		ocation - (City or To	wn, State
Baltimore,	Pages ment of tant: If it		1 ☐ Burial 2X☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify)		1 Coun	ty Cr	emat	ion 1				svil		MD
Rall	permit. Pages Department of H important: If ite any injury or of		21. Signature of Funeral Service Licens	Haux	4	H. S	Name an AIGHT ykesv	d Addres FUN ille	s of Facilit ERAL • MD	HOME 2178	& CHAI 84 (410	PEL)-79	P.A 5-140	00 (Bo	ox 195
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of			h. Do not ente	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rrest,			Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)			hot woo	end Ti	o The	Hea	d					Onser and Deam
	Examiner		f	Due to (or a	is a conseq	uence or):									
	bed is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a conseq	uence of):									
<u>,</u>	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):								+	
3/60,	ate be nysicia he buri	cal	· ·	d											
X S	ertifica ding ph	Med	IF FEMALE:	23c. If yes, outcom	o of program			-							
C. Box	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pro Other (sp						23d. Date Mont		ry Day Year
7	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions co	ntributing to death	but not resi	ulting in the un	derlying ca	ause give	n in Part I.		23e. Did to			oute to th	e cause of death?
ord	require een sly										1 🗆 \	/es 2	No 3	B Proba	ably 4 Unknown
Records,	sician: The law certificate has b irector, page 2 sl	Completed											pr	or to con ath?	osy findings available npletion of cause of 2 No
VItal		Bec	25. Was case referred to medical examiner?							of Death	(Check only o		' ' '	, 100	20110
0	Physi r this c ral dire	. To	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpat 28a. Date of In		ER/Outpatient		A Othe 8c. Injury	4 🗆 140		ne 5 Resid				At scene
o	Attending Physician: or death. actor: After this certific by the funeral director.	atlon	1 □Natural 5 □ Pending 2 □ Accident investigation	Found 1/24	ay Year)	Injury Facility 6:31	0	Work	? 'es 2 💢		subject :				
DIVISION	or Attendation of Att	Certification:	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In		ome, farm, stre	et, factory	, office		2	28f. Location (S City or Tow	Street ar vn, State	nd Number	or Bural	Route Number,
_	e Hospital or Al 124 hours after of Funeral Dirac letely filled in by		29a. Certifier 1☐ Certifying Phy	rsician: To the hes	t of my kno	SUNC	occurred :	at the time	e date an	1	aney brun	, MC			
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medicel Exam		of examina										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier Amatic Kyryhi	relimi)			29c	. License	number CME				te signed uary		2005
3	11		30. Name and address of person who can address of person who can be a south		death (Item			an St	reet	, Bai	ltimore	, Ma	aryla	nd 2	1201
	Sta		31. Date filed (Month, Day, Year)	400	r's Signa							-			
Uh	Registr	_	JAN 2 6 2	005	like	ture A	cook	9							
	1411 1 / USA 1/50	W 1				9									

			For State Registrar	State of	Maryland / [Эера		of He	ealth a			iene	05	019	901
	Physici		1. Decedent's Name (First, Midd Elsie		cciuti					1	2. Date of Deat	23 1	7.006	3. Time of	of Death A M
	/Medio Examin		4a. Facility Name (If not institution	. •			4b. City, To					4c. Count		17.5	
	Funeral		Union Memoria 5. Social Security Number	6. Sex	7. Age (In yrs. last bin	thday)	If Under 1	Year	ore C	•	8. Date of Birth		V/A 9. Birthp	lace (State	or Foreign
	Director		212-50-3353 Usuel Residence of Decedent	1□M 2\\ F	89	Yrs.	Months I	Days	Hours	Min.	8. Date of Birth (Month, Day, June 20	, 1915	Mar	ÿland	
	how the		10a. State 10b. County	•	10c. City, Town		cation e City						1	Od. Inside C	•
	he Ma	Director	Maryland N/A	· · · · · · · · · · · · · · · · · · ·	Daiti	IIOI	10f. Zip C				10	0g. Citizen of	What Cour		s 2 🗆 No
	3a or	DI	3610 Crosslar	nd Avenue				213				-	S.A.	itiy:	
	death	Funeral	11. Marital Status		dent Ever in U.S.	13.	.1		panic Orig	in? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ce - Americ		
36	iges 1 and 2 should be filed within 72 hours after death with the Marylend it of Health and Mental Hygiene it if item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Medical Examinational Expedited at	oy Fu	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorce	rried 1 Tyes	2 XNo e		1 ☐ Yes 25		Specify:		,	Specit		ite	
2-00	72 hou natura lical E	ted	15. Deceder	nt's Education est grade completed)		Deced (Give	lent's Usual (Occupat	ion ring most	of workin	ng.	16b. Kind of B	Susiness/Inc	dustry	
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1d 2	filed with Hygiene other than	Be Co	17. Father's Name (First, Middle,	, Last)						r's Name	(First, Middle, M			·	
ylar	2 should be f and Mental h is marked of	ToB	Frank		rucha					ary		Svec			
Maryland 21215-0036	d 2 shi th and th and traum		19a. Informant's Name/Relation: Paul Ricciuti				ig Address (S Cross				Route Number, Baltime	-			
	of Health item 27 other tr		20a. Method of Disposition		20b. Place of							20c. Location			
Baltimore,	Department of I Importent: If Its any injury or o		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (3	Specify)	JIAIO	y R	edeeme	r		1-27		Baltin			
Ball	perrit. Page Department of Importent: if any injury or once.		21. Signature of Plineral Service	Licensed	1 02						timore, c. 530				
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that can be controlled to the cause on each	aused the death. Do r	not ent	er the mode	of dying,	such as o	cardiac or	r respiratory arre	est,	JI U K	Approxima Interval Be	ite itween
	Physician		Immediate Cause (Final disease or condition	_a CENE	BLAL AND)	(H)								Onset and	Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequence	of):	1 A	nne.	31					721	mins
	P #	ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):		4.0	4.40				1		***
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. SKK	DID DEVE or as a consequence	<i>ง)])</i> อก:	ANT P	4514	MH					3 4t	1115
68760,	ate be executed hysicien and the burial-transit	calE		d											
k 68	death certificate be executed e attending physicien and of for use as the burial-transit		IF FEMALE:	00. 11				-							
Box	attend for us	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live bi	come of pregnancy rth 2 Fetal death ant at time of death		Ectopic preg						ite of delive onth		Year
P.O.	that the de led by the a detached f	hysi	9 Unknown	9□ Unkno	wn										
Ś	sign Sign	b	Part II. Other significant condition	ions contributing to de	ath but not resulting in	n the ur	nderlying cau	ise given	in Part I.		23e. Did tob	acco use con s 2 No	tribute to th 3 □ Prob		death? Unknown
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I Re		Some									autops perform	red?	prior to cor death? 1 🖺 Yes	npletion of a	ause of
Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Other			(Check only one				
of		n: To	1 Yes 2 No 27. Manner of Death	28a. Date o		tpatien Time of njury		: Injury a Work?	4 🔲 Nur		ne 5 🗌 Reside 8d. Describe ho			/)	
sion	Attending For death. ector: After by the funera	catlo	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	tigation			М	1 🗀 Ye	es 2 🗆 N						
Division	i or At after d Direct J in by	Certification:		mined 288. Place	of Injury - At home, fa ng, etc. (Specify)	rm, str	eet, factory, o	office		2	8f. Location (Str City or Town		ber or Rura	i Route Nun	ıber,
	To the Hospitei or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		ing Physician: To the I Exeminer: On the ba and mann	sis of examination an										s)
	To t Withi To tl	Z	29b. Signature and title of certific	MSIDENT			29c. l	License	number		012	d. Date signe	d (Month, i	Day, Year)	5
	1		30 Name and address of a	1-(2.701	of death (Item 02c)	Tvac	Print's	43	344	6-	11/2 1	ur vir IV	1 13	1005	/
	0		30. Name and address of person MUGA PON DCA 31. Date filed (Month, Day, Year	MARIO 20	equivar's Signature	11/16	15/11/	PA	UWA	n/	DIZ JI BANMU	ONE, 1	YANYU	AND Z	7/2/8
	Sta Registr		JAN"	2 6 2005 b	egi frar's Signature	4.	food								

		•	1 - For State Registrar	State of Mar	-	epartment of He Certificate of De		ental Hygiei Reg.:	211115	01902
			Decedent's Name (First, Middle, Last	st)		1		2. Date of Death		3. Time of Death
	Physicia /Medic		HELMA T.	CHEN	ROX	31N50N		JAN.	Year 200	5 1:30P.M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death		4c. County of Deat	th 0
			2000 ALLI:	S STRE			POLIS	5	ANNE AI	RUNDEL CO.
	Funeral		5. Social Security Number 6. S	ex 7. Age (i □M 2.20∫F	In yrs. last birth		Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent		00			JUNE 4,1	718 / 1/	TRYZAND
	deeth with the Maryland ms 23e or 28e-f show rmust be notified at		10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	e-f st	ctor	MARYLAND ANNEAN	RUNDEL CO.	An	UNAPOL	15			1 ☐ Yes 2,⊠No
	ith the	Director	10e. Street and Number	-		10f. Zip Code		10g.	Citizen of What Co	ountry?
	23e	ral	2000 ALL.		REET		21401		45	A.
	er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	 Was Decedent of Hisp If Yes, specify Cuban, 	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
0036	d within 72 hours after deeth with the Marylan jeen . I then "natural", or Items 23e or 28e-1 show I the Madical Examinat must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ₺No	Specify:		Specify: 12	IACV
ş	2 hou	ted	15. Decedent's Ed	ducation	16a. I	Decedent's Usual Occupation	on	16b	. Kind of Business	Industry
2 2	within 72 ene. then "na he Medic	Completed	(Specify only highest gra	College (1-4or 5+)		Give kind of work done dur life. DO NOT use retired)				, ,
7	ad wit	Con	12 TH GRADE			DUPERV				E STATE HOSP.
and	be filed Ital Hygi Id other	Be	17. Father's Name (First, Middle, Last)		(1)	11		(First, Middle, Maid	-	
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ă Z	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (1 ype, Print) 1 N SR, (50)		831 LIBE	_			,
_	1 and Health tem 27 other to		20a. Method of Disposition	NOK, (SO)	20b. Place of	Disposition (Name of	Z/1/10/	ate 20c	Location - City or	MD. 21/33 Town, State
ב ב	ages ant of it: If II		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific		-	; crematory or other place) LIS HEM. GARD	me 11- 2	5-05 1	NNAPOL	IS MADI
altımore,	permit. Pages Department of Important: If I any injury or one		21. Signature of Funeral Service Licer		HNIVAR	22. Name and Address	of Facility	380111	JP FILE	VERAL HOME
ñ	permit. Departimport Import any inj		Wethich	NWI	leams	397821	FULTO.	N AVE.	BALTO,	MD. 21217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do n	ot enter the mode of dying,				Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a c						
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		-	State of M	Maryland / Department of Heal Certificate of Dea	ath	ene 005 01903
	Physici /Medic	an al	1. Decedent's Name (First, Middle, Last) JEREMIAH 4a. Facility Name (If not institution, give street and numbe	RICHARDSO 1) 4b. City, Town, or Loca	2. Date of Death Month JAN.	Day Year 3. Time of Death 4:30 PM
1	Examin Funeral Director		751 W. SARATOGA	ST. APT4/4 BALT Age (In yrs. last birthday) If Under 1 Year If U	Juder 24 Hrs. 8. Date of Birth (Month, Day, JAN, 27)	NIA
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23e or 28e-f show ther then "naturel", or items 25e profiled at eart, the Medical Examinat must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND 10e. Street and Number 751 W, SARATOG 11. Marital Status 12. Was Decedent 12. Mas Decedent 12. Maryland 13. Maryland 14. Maryland 15. Maryland 16. Saratog	A ST. APT. 414	MORE CIT	10d. Inside City Limits 1 □ X ves 2 □ No 9. Citizen of What Country? 14. Race - American Indian, Black, White, etc.
215-0036	nin 72 hours after n "naturel", or ite Medical Examine	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	Specify: BLACK 6b. Kind of Business/Industry
Maryland 2121	ges 1 and 2 should be filed within 72 hc tt of Heath and Mental Hygiene. If item 27 is marked other then "natuu or other treumatic event, the Medical	To Be Com	12 THGRADE 17. Father's Name (First, Middle, Last) TULIUS	RICHARDSON L	Mother's Name (First, Middle, M	FLOOD
Baltimore, Mary	t. Pa rtmen rtent:		19a. Informant's Name/Relationship (Type, Print) DEBRA TACKSON (DAUK) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	ARBUTUS CEMEJE	RD, SYKES Bate 2 Ry 01-28-05 L	VILLE 140. 21784 Oc. Location - City or Town, State SALTIHORE MARYLAND
Ba	permi Depa Impo any ii		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not enter the mode of dying, sur	FULTON AVE., ch as cardiac or respiratory arres	TR. FUNERAL HOME BALTO, MD 2/2/7 st, Approximate Interval Between Onset and Death
3760,	/Medical Examiner / Medical Examiner / Medical Italian and Italian Ita	dicai Examiner	Sequentially list conditions, Tarry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of): As a consequence of): as a consequence of):	ARCI101V	1 Week
P.O. Box 6	that the death certific: ed by the attending pl detached for use as t	Physician/Med		2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
	w requires that the bean signed by should be detact	by	Part II. Dther significant conditions contributing to death $D E M E N 71 A$	but not resulting in the underlying cause given in		accoluse contribute to the cause of death?
tal Rec	iicien: The law r certificale has bu rector, page 2 sh	e Completed	25. Was case referred to medical	26	24a. Was an autopsy perform 1 ☐ Yes 2. Place of Death (Check only one	prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No
Division of Vital Records,	ing Phys	Certification: To Bo	examiner? Yes 2 No	atient 2 ER/Outpatient 3 DOA Other: 4	Nursing Home S Resider 28d. Describe how	ice 6 □Other (Specify)
Div	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	al Certif	4 Homicide building. 29a. Certifier Certifying Physician: To the be	etc. (Specify) st of my knowledge, death occurred at the time, da	City or Town,	State) use(s) and manner as stated.
	To the Horizon 24 To the Fi	Medical	29b. Signature and title of certifier Accedu olow KA	29c. License num	mber 29	d. Date signed (Month, Day, Year)
4	JHZ		V /		10272 1026, MD	
	Sta Regist	ate rar	30. Name and address of person who completed cause of DON NORTH GREE 31. Date filed (Month, Day, Year) JAN 2 6 2005	strar's Signature of Joseph	, , , , ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per Verb., G839 01/26/05dbb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ichardson **Physician** orraine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bluehill Road Woodlawn If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs. **Funeral** Number 6. Sex 8. Date of Birth Month, Day, 9. Birthplace Country) 216-20-7910 Months 1 □ M 2 🗹 F Director Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside Oity Limits 28e-f show 7 is markad other than "netural", or items 23e or 28e-f show traumatic evant, I'm Medical Examiner must be notified এ Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 2227 Funeral 2121 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is merked other than "netural", or item any injury or other traumetic event, the Medical Eventrien, once. 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced BIACK Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or Work nufacturun 17. Father's Name (First, Middle, Last) Be Mother's Name (First, Middle, Maiden Sumame) Richardson 19b. Mailing Address Street and Number or Ruryl Route Number, Chr. HR) 3105 CCKY
20b. Place of Disposition (Name of place) beera 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory Hark Baltimore MD Greene Fundral Snc. * 4 ☐ Donation 5 ☐ Other (Specify) 21-05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn aug Randalstown, MD 21132 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical e to (or as a consequence of) Examiner Sequentially list conditions, fany leading to formediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the attending physician and hed for use as the burial-transit to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 KeFlu 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 27. Manner of leath Other: 4 Nursing Home The Nursing Home Character (Specify) Daughters 3 DOA o Home 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attanding Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ass of person who completed cause of 30. Name and add 23a) (Type, Print)

State Registrar

IAN 2 6 2005

			1 - For State Registrar	State of Mary			of H	ealth a		lental Hy		200	poliny	01905
		3	Decedent's Name (First, Middle, La	ist)						2. Date of De.	ath			3. Time of Death
ŗ.	Physici		Myrtle Ru	itt						Jan. 1	8, 2	2005	ear	10:45A.M
1	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, 7	Town, or	Location o	f Death			. County of	Death	1
			1822 Sims Lane			Har	nove	r				Anne	Aru	ndel
ľ	Funeral Director		174-10-7518	Sex 7. Age (In 1 ☐ M 2 1 F	yrs. last birthday) 79 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs Min.	8. Date of Birl (Month, Da 3/10/.	lh Year 1925	9	Birthp Court Ma	lace (State or Foreign try) ryland
	and w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation							1	Od. Inside City, Limits
	sho	ō												1 ☐ Yes 2 No
	the A	ect	MD Anne A	rundel	Hanover	10f. Zip	Code	·			10g Ci	tizen of Wha	at Cour	atry?
	with	ā	1822 Simms Lane				076				-	USA		,
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race -	Americ	an Indian,
(0	riter of	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo	1				, Puerto	Rican, etc.)		Black,		
ĕ	ours a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	NO No	Specify:				Specify:	Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "netural", or ttems 23s or 28s-f show ent, the Madical Examinat must be notified at	Completed by	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual	Occupa	ation during most	of worki	ina	16b. F	(ind of Busin	ness/Ind	dustry
7	ithin	np le	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wor DO NOT us)		9				
7	ygier ygier yer th	S			Bar	Tende	er			(=)		avern		
n n	be fill H dott	Be	17. Father's Name (First, Middle, Last							(First, Middle,		,		
<u>}</u>	ould Men narke	은	James O.H. Gordo						_	a Franc		Annual Control of the Control		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23s or 28a-1 show eny injury or other treumatic event, the Madical Examiner must be notified at once.	1	19a. Informant's Name/Relationship (George Lloyd / S							al Route Numbe Baltimor	-			
	1 and 1ealth am 27	0.0	20a. Method of Disposition						1.5	Date		ocation - Cit		
0	ges it of H if ite		1 Burial 2 XCremation 3	Themoval nom State	ob. Place of Dispo cemetery, cre									
ŧΪ	t. Partmer	g g	' 4 □ Donation 5 □ Other (Speci		Balt/Was				-	-				ryland
Baltimore,	Depar Impo	0	21. Signature of Funeral Service Lice	A Car		2. Name and				eck Fur			-	
	*		230 Ratt Stor the dispase or son	unlications that caused the								e1, M	ary.	Land 20707 Approximate
	Physician		23a. Part1. Enter the disease, or con shock, of hear failure. List only Immediate Cause (Final disease or condition			Risn.			cardiac	or respiratory at	1651,			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor										
μ	- Adminici		Sequentially list conditions, if any, leading to immediate	D	o my u	V they							_	17
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):		-	1						5~~
	te be executed ysician and le burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a cor	rsequence of):	1-18-4	ni —	Dur	Yh.					
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687				_ d										
×	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy							23d. Date of	of delive	inv.
Вох	eath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pre Other (spe					137	Month		Day Year
o.	the d y the	ıysi	1 Yes 2 Do	9☐ Unknown			,,							
α.	that ned b	y P	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying ca	ause give	en in Part I.		23e. Did to	obacco	use contribu	ate to th	e cause of death?
ds.	puires n sign	d by	- 017	TO NOTHER	-					101	res 2	□ No 3	Prob	ably 4 Unknown
Records,	w require been si should I	Completed	- >	2811	(1 s . 1n :	L				24a. Was	ап	24b. We	re auto	psy findings available
Re	The lav	mc		4 31	Man.	1000					med?	prio	r to cor	npletion of cause of
Vital			25. Was case referred to medical					26 Place	of Death	1 Yes	2 X No) 1	Yes	2 No
		o Be	examiner?	Hospital:	2 ER/Outpatier	nt 3 DO.	A Cthe			me N Resid	-	6 □Other	(Snecih	()
o	g Phys er this eral di		27. Manner of De th	28a. Date of Injury	28b. Time o		Bc. Injury Work			28d. Describe I			opeoy	,
<u>o</u>	nding th. :: Afte	atio	1 Satural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	М		<br Yes 2 □ i	No					
Division	Atter	Certification;	3 Suicide 6 Could not be determined	286. Place of injury -		reet, lactory,	, office			28f. Location (S City or Tox	Street a	nd Number	or Rura	l Route Number.
ā	el or s afte il Dir	Sert	4 [] nomicide	building, etc. (S)	рөспу)					City of Tov	vii, Stati	9)		
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral.	edicai (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my miner: On the basis of examiner stated.	knowledge, deat mination and/or in	h occurred a vestigation,	at the tim in my op	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s date an) and mann d place, and	er as st I due to	ated. the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifier			29c.	. License	number			29d. Da	ite signed (/	Month, i	Day, Year)
	/	10					O	242	76			1.2	1-0	~
	h	Į.	30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Print)								
	9		2001		- Ba	eltimi	Ne	UD	20	224	Sir	non S	xa	la, N.O.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature									
	Sioti		.JAN Z 6	11115 18000	M	Roselle	ji i							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ay 2 KUEERS AMES 0 05 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death pspital Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year OUN-5. Social Security Number 212-44-324 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 17 M 2□ F Months Days MD 10.19.19 Ö Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County BALTIMORE 1 XYes 2 □ No

10f. Zip Code

1 ☐ Yes 2 🗷 No

nventon

1020 Mt. Holly 20b. Place of Disposition (Name of cemetery, crematory or other place)

King

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Park

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

21217

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Distributor

Annie

eden

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

02.01.05

18. Mother's Name (First, Middle, Maiden Surname)

Taughn Corene Funeral Sanices 55 Bathmore National Pike Balto. W 21229

Street Baltimore MD 21229

Funeral Director in than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at i 2 should be filed within 72 hours after n and Mental Hygiene. I is marked other than "naturel", or Ite Baltimore, Maryland 21215-0036 or other treumatic event, Pages 1 and 2 ment of Health a ant: If item 27 Is permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

For State Registrar

10a. State

10e. Street and Numbe

2025

W. North

15. Decedent's Education (Specify only highest grade completed)

Regers

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

H.

19a. Informant's Name/Relationship ype, Print)

' 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Logers

1 BBurial 2 ☐ Cremation 3 ☐ Removal from State

10th grade

Danie

Pamcia

20a. Method of Disposition

Director

Funerai

þ

Priysician /Medical **Examiner**

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed After 1 death.

Records, P.O. Box 68760 Division of Vital or Attending after death Director: within 24 hours a

To the Funerel C o the Hospitel

Examiner Physician/Medical þ Completed 25. Was case referred to medical examiner? Be 2 27. Manner of Death Certification:

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25

2 No

5 Pending investigation

6 Could not be

30. Name and address of person who completed cause of deat

title of certifier

1 🗌 Yes

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

29b. Signature an

4 Homicide

Hospital:

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

Inpatient

28a. Date of Injury (Month, Day Year)

Avenue Apt. #2

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates:

College (1-4or 5+)

Sister

3 Ectopic pregnancy 5 Other (specify)

3 DOA

W. BALTO.

М

28c.

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

10g. Citizen of What Country?

16b. Kind of Business/Industry

20c. Location - City or Town, State

Randallstown, MD

Approximate Interval Between Onset and Death

USA

14. Race - American Indian Black, White, etc.

Specify: Black

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∐ Yes 2 [X/No 1 TYAS 2 1 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred Injury at Work?

1 ☐ Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On, the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number DD3035 29d. Date signed (Month. Dav. Year) 22 20

BAUD. MD

31. Date filed (Month State Registrar

2 6 2005

DHMH 17 Rev 1/2001

(Item 23a) (Type, Print)

12000

Registrar's Signature

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			1 - For State Registrar	State of Maryl		artment of H		ınd M		iene	005	01907
		*	Decedent's Name (First, Middle, Last)						2. Date of Deat	h	- 	3. Time of Death
	Physici /Medio		Alphonsa Reynar	d Ragin					Month January	7 14,	2005	4:00 AM
	Examin		4a. Fecility Name (If not institution, give st	treet and number)		4b. City, Town, o	or Location of	f Death		4c. Co	ounty of Dea	ath
			Holy Cross Hospit				r Spr				tgome	
	Funeral		5. Social Security Number 6. Sex 15	M 2DE	rs. last birthday) 1 Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day,	Year)		rthplace (State or Foreign Jountry) Larendon, SC
	Director		Usuel Residence of Decedent		1				Oct. 23	, 19.	0.	rar endon, 50
	yiand		10a, State 10b, County	10c	City, Town or Lo	cation						10d. Inside City Limits
	a-fs	ctor	Maryland Montgome	ry	Silver S	Spring						1 ☐ Yes 2 ☐XNo
	ith th	Director	10e. Street and Number			10f. Zip Code			1	0g. Citizer	of What C	country?
	ath w	rai	603 Sligo Avenue			2091				U.S.		
	er de litem	une		2. Was Decedent Ever i	n U.S. 13.	Was Decedent of H 1 Yes, specify Cub	lispanic Orig an, Mexican,	jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	14.	Race - Am Black, Whi	eńcan Indian, ite, etc.
36	irs aft	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Sp	ecity: B	lack
ŏ	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Madigal Examinar must be collited at	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occur	oation			16b. Kind	of Business	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most d)	or workin	ng			
2	ed will ygjen ver th	Con		5+	Acc	countant					Elec	tric
nd	be filed of the other of the ot	Be	17. Father's Name (First, Middle, Last)						(First, Middle, A	Maiden Su	mame)	
<u>\S</u>	J Men narke	2	Theodore A. Ragin		405 M-10				Rivers	0	0	7.011
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at Once.		19a. Informant's Name/Relationship (Type Ansley Bernard Ra	•		ng Address (Street						
ē,	Heal Heal tem 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of						r Town, State
JOE	Pages ent of ht: if i	l	1 ŽiBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)		•	natory or other plan A.M.E. C	· 1	/22/	05	Pine	ewood	, SC
Baltimore,	mit. I partm yortal / inju		21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility	,	-			, 20
ä			Dennis Ot	Umeun	- C	ommunity 53 Manni	Funer ng Ave	al H	lome Sumter,	SC 29	9150	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	leath. Do not ent	er the mode of dyir	ng, such as c	cardiac or	r respiratory arre	est,		Approximate Interval Between
	Physician	in is	Immediate Cause (Final disease or condition	SEPTICEMI	A							Onset and Death 2 DAYS
	/Medical Examiner		resulting in death)	Due to (or as a con								
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8760,	icate be executed physician and s the burial-transit	dicai	d.									
9	ng ph	Med	IF FEMALE:									
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pre 1 Live birth 2 F	etal death 3	Ectopic pregnancy	y			23d	. Date of de Month	olivery Day Year
o.	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify) _						
٥.	The law requires that the death certific ate hes been signed by the attending p page 2 should be detached for use as	Ph.	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use	contribute t	o the cause of death?
Records,	uires tha signed Id be del	d by	END STAGE RENAL DI	SEASE					1 □ Ye	s 2 X	lo 3 □ P	robably 4 Dunknown
00	w requires been significant to should to	Completed	PULMONARY EMBOLISM						24a. Was ar	1 2	4b. Were a	utopsy findings available
	The lav te hes age 2	шо	ANTEMTA						autopsy perform 1 Tes 2	V .	prior to death?	completion of cause of
Vita		BeC	ANEMIA 25. Was case referred to medical				26. Place	of Death	(Check only one		1016	20110
>	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 📉 No Ho	ospital: 1 📉 Inpatient :	2 ☐ ER/Outpatier	t 3□ DOA Oth	ier: 4 □ Nur	sing Hom	ne 5 🗆 Reside	nce 6	Other (Spe	ecify)
Division of	ding Pi h. After ti funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor	rk?		8d. Describe ho	w injury o	ccurred	
<u>S</u>	Mtendi death ctor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	On Dian dian	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Yes 2□N		PAS Logation /Ct	root and A	lum basas O	tural Davida Mumbas
$\overline{\leq}$	or Attendate death Diractor:	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	at nome, tarm, str ecify)	eet, factory, office		2	City or Town		umber or H	lural Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 🔀 Certifying Physi	cien: To the best of my	knowledge, deatl	occurred at the fir	me, date and	j place, a	nd due to the ca	use(s) an	d manner a	s stated.
	ne Ho ne Fui sletely	Medical	(Check only 2 Medical Examinations)	er: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death	h occurre	d at the time, da	te and pla	ace, and du	e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifler	(1) (A)	77-	29c. Licens	e number		29	d. Date s	igned (Mon	th, Day, Year)
	*		1 effect	rell	L W	D47	7188		Ja	anuar	y 14,	2005
	10		30. Name and address of person who con		Item 23a) (Type,	Print) Montrose	₽đ	Rock	ville 1	νD 20	852	
			Jeffrey A. Perlmut 31. Date filed (Month, Day, Year)	ter, M.D.					· L L L L	20		
	Sta Registr		1AN 2. 6		we do	porte	7					

			1 - For State Registrar	State of Maryla		artment of H			giene	 5 01908
	Physici /Medi Examir	cal	DORSEY ELWOOD A. Facility Name (If not institution, give seems).	RHOADS SR	•	4b. City, Town, or	Location of Death	2. Date of Dea Month JANUAP	Day Yea	5 5:45 PM
	Funeral Director		GOOD SAMARITAN 5. Social Security Number 6. Sex	MOSPITAL	s. last birthday) Yrs.	BALTI If Under 1 Year Months Days		8. Date of Birth (Month, Day APRIL		Birthplace (State or Foreign Country)
	the Maryland 28a-f show	Director	MD 10b. County		City, Town or Lo	RE				10d. Inside City Limits 1 X Yes 2 □ No
	23a or 2	ai Dir	10e. Street and Number 4600 ANNTANA	AVENUE		10f. Zip Code	21206		10g. Citizen of What USA	Country?
5-0036	after dea or Items	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:WW I		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 🏖 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: W	
21215-0	d within 72 hours giene. er than "natural", the Medical Exc.	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupa kind of work done o DO NOT use retired O MECHAI	turing most of work)	king	16b. Kind of Busine AUTO ME	
Maryland	12 should be filed within 7 h and Mental Hygiene 7 is marked other than "r fraumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) DORSEY E • RE				MARY J	ANE WOO		
	and 2 shealth and 27 is m		19a. Informant's Name/Relationship (Ty) EILEEN MONACO	daughter					r, City or Town, State ${ m LLE}$, ${ m MD}$. ,
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)		ARKWOO	natory or other place D CEMETI	ERY 01/			LLE, MD.
Balt	permit. Depart Import any inj		21. Signature of Fune al Service License	ACO		16924 Y	ORK RD.	MONKTO	N, MD 2	& SONS CO. 1111
8760,	/Medical Examiner /Medical Examiner the burial-transit	ai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi	equence of):	NEMECT!		or respiratory an	est,	Approximate Interval Batween Onset and Death
O. Box 6	The law requires that the death certificate be executed attending physician and base 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital déath 3 🗌	Ectopic pregnancy			23d. Date of o	delivery Day Year
Д	quires that n signed b uld be deta		Part II. Other significant conditions con	tributing to death but not re	esulting in the un	nderlying cause give	n in Part I.		bacco use contribute	to the cause of death? Probably 4 Tonknown
Vital Records,	The taw requir ate has been si page 2 should	Completed by	Tachena Me	llitus	200 1/4			24a. Was a autops perfori	sy prior t	
Division of Vita	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes No H 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: Impatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	ER/Outpatien 28b. Time of Injury home, farm, str	28c. Injury Work M 1 🗆 Y	at ? /es 2 \(\sum \text{No} \)	ome 5 🗌 Reside 28d. Describe ho	ence 6 Other (S) ow injury occurred	pecify) Rural Route Number,
۵	To the Hospital o within 24 hours aft to the Funeral Di completely filled in	edical Cer	(Check only 2 Medical Examin	icien: To the best of my kier: On the basis of exami	nowledge, death	occurred at the tim	e, date and place, inion, death occur	and due to the co	ause(s) and manner	as stated.
),	To the I To the Complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
L	11		30. Name and address of person who con TANIA LAMBA, MIS	mpleted cause of death (Ite	эт 23a) (Туре, Н РАVЕ	Print) N BLVD	BALTIMO	RE, MI	2123	١.
	Sta Registr	18	31. Date filed (Month, Day, Year)	32. Registrar's sign	nature	Scarle	,			

		1 For State		aryland / Depa		of H	ealth ar		al Hygi	ene) 5	01000
		Registrar 1. Decedent's Name (First, Middle, Las	t)	06/	incate	OIL	Jealii	2 D	ate of Death	3	1 0	3. Time of Death
Physic	ian	CALVIN	LEON	ROBINS	ON			N	fonth	Day	Year	
/Med		4a. Facility Name (If not institution, give		KODINS		01470 05	Location of		N. 2	3 2005 4c. County		12:45 ^{A M}
Exam	ner	MULTI-MEDICAL			4b. City, I			Death		1		_
		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under		NSON If Under 24	4 Hrs. 9 D	ate of Birth	BALT		
Funera Director			M 2□F	75 Yrs.	Months	Days	Hours	Min. (A	Aonth, Day,		Coun	lace (State or Foreign try)
		Usual Residence of Decedent		73					2/15/	1929	MAR	YLAND
ylanc sow		10a. State 10b. County		10c. City, Town or Lo	cation						10	Od. Inside City Limits
Mar	to	MD N	/ A	F	BALTI	MOR	E CI	ITY				XXYes 2 □ No
death with the Maryland ms 23a or 28e-f show	irec	10e. Street and Number			10f. Zip				10	g. Citizen of W	hat Coun	try?
h wit	O E	3015 HANLON	AVENUE			2	1216			USA	4	
deat	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decede			in? (Specify Y Puerto Rican	res or No-	14. Race	- America	an Indian,
or its	F	1 Never Married 2 Married	1 Tyes 2 1	No	1 ☐ Yes 2		Specify:	ruento moan	1, 6(0.)		, White, e	etc.
5-0036 72 hours after naturel; or its	d by	3 Widowed 4 □ Divorced	Year or Dates:	US ARMY	_					SpeBil	ACK	
21215-0036 od within 72 hours att giene. er than "naturel; or the Mad call Experience.	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual kind of worl	Occupa done d	ition Juring most o)	of working	1	6b. Kind of Bus	siness/Inc	dustry
within ene.	idu	Elementary/Secondary (0-12)	College (1-4or 5	D+)						WESTI	1GHO	USE CORP
d 21 filed v Hygie other t		12TH		ELEC	TRON	IC	DEVEL			laiden Sumame		CORP
be fi	Be	17. Father's Name (First, Middle, Last)										
Ylan	5	(UNKNOWN)	0.00	400 140 11		(0)				AMPTON		
Nore, Maryland 21215-0036 uges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "naturet," or items 23s or 28e-1 show or other treumetic event, the Madical Examination with the mailter and the state of the		19a. Informant's Name/Relationship (7) SORAYA A. ROB		DAUGHTER	-					City or Town, S LTIMOF		MD 21218
s 1 a f Hei item othe	-	20a. Method of Disposition	,	20b. Place of Dispo cemetery, crer	sition (Nam	e of		Date		0c. Location - 0		
Itimol	1	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		REMA			1/25/	/05 C	ATONS	7 T.T.	E, MD
Baltimore, permit. Pages 1 a Department of Hes Importent: If item any injury or othe one.		21. Signature of Funeral Service Licen					s of Facility	HOWEI.	I. FIIN	VERAL	HOME	21207
Bal permii Depar Impor		11/1/1/1/1/10	/n·/X	From 4	600 I	TBE	RTY 1	HETCH	TS AV	/H' RA	L.T.T.N	ORE, MD
		23a. First Enter halsease, or complete hook, or hear failure. List only	olications that caused	the death to not ent	er the mode	of dying	g, such as ca	ardiac or resp	oiratory arre	st,	HA TE	Approximate
Physician		Immediate Cause (Final	one cause on each in									Interval Between Onset and Death
Physician /Medical	_	disease or condition resulting in death)	a	NEUMO/ a consequence of):	U/14				-		-L	1445
Examiner			to the	CIVENITI	4						1	AUS
	je l	Sequentially list conditions, if any, leading to immediate cause. Entire funderlying Cause (Disease or injury	Due to (or as	a consequence of):								
uted d ansit	Examiner	Cause (Disease or injury that initiated events	6									
60, be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):								
0 5 0	cai		d									
ox 68 certificat nding phy	ledi											
Box eath cert attendin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pre	ananev				23d. Date		,
Records, P.O. Bc The law requires that the death te has been signed by the atter age 2 should be detached for u	icia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		Other (spe					Mon	th	Day Year
P.O.	hys	9 🗆 Unknown	9L) Unknown									
S the	by F	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying ca	use give	in in Part I.	2				e cause of death?
equire en signal	ed								1 🗍 Yes	s 2□No	3 🗍 Proba	ably 4 Honknown
Records, the law requires the hare been signed as a should be one	Completed							2	4a. Was an autopsy			sy findings available
Vital Rec s cian: The law certificate has b	E O							_	perform	ed?_ de	ath? ⊒Yes	,
- 0	a)	25. Was case referred to medical					26. Place o	of Death (Che				
of Vita Phys cian: rthis certific	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 ER/Outpatier	t 3 DO	Othe				nce 6 Othe	(Specify)
	i.	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	28	c. Injury	at	28d. C	Describe hov	w injury occurre	d	
Division of or Attending I after death. Director: After In by the funer	atio	1- Natural 5 ☐ Pending 2 ☐ Accident investigation		, , , , , , , , , , , , , , , , , , , ,	М		res 2□No	0				
ViS Atte	ific	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, str	eet, factory,	office		28f. L	ocation (Stre	eet and Numbe	r or Rural	Route Number,
Display	Certification:	Tomode	building, et	c. (Specify)					y o o,	Olalo)		
Divisic To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the y				of my knowledge, death f examination and/or in								
he H in 24 ihe Fi plete	Medical	one)	and manner sta	ated.	vestigation,	uni iniy op	imon, death	1 occurred at	the time, da	te and place, a	id due to	tne cause(s)
To t Yeith To t	Σ	29b. Signature and title of certifier					number			d. Date signed		-
, ,	1	Spople	MD		I	000	0231	021	3	5 MAG	44	2005 COLEMON
6/1		30. Name and addre s of person who			Print)		7	7780	YOKK	RUA	40	MOZEN
1	1	Sh ALEUNIY) /	YUI	LTIM	EDIC	AC	CTR	Be	allemon
975	ate	31. Date filed (Month, Day, Year)	32. Pagistra	ar's Signature								
Regis	trar	JAN 2 6 20	UD Stales	w # Ag	made!							

DHMH 17 Rev 1/2001

Stevie Reed, Jr. amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05-00231 crn Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 09ay 2005° Stevie Reed, Jr. 6:48 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Funeral Days Hours 1∏M 2□F 577-11-0852 Director 22 Yrs Feb. 15, 1982 Connecticut Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
shir: if Item 27 is marked other than "natural; or Items 23a or 28e-1 show any in the Items 23a or 28e-1 show arry or other traumatic event, the Marical Extense and Item Asset of Items and Items and Items are or other traumatic event, the Marical Extense or and Items ar 10d. Inside City Limits Virginia Prince William 1 X Yes 2 □ No Directo Dumfries 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22026 USA 4973 Buena Vista Dr. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 to Yes 2 □ No If Yes, Give Year or Dates: 2001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ₩ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 2883-Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Multiple Launch Rocket System
Repairer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 1 Yr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gail Gardner Stevie Reed, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Gardner- Mother 12813 Kilgore Rd. Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department (Importent: if any injury or Gate of Heaven Cem. 101/25/2005 Silver Spring, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tiple Music disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of 2 🗆 No 1 Yes 2 🔲 No (es To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1

Yes 2 □ No 2 1 Inpatient 2 XER/Outpatient 3 DOA 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: motor vehicle 1 Natural 5 Pending investigation after death. 1 Yes 2 No investigation
6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Place of Injury - At home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner is state. -9-05 2 Accident 3 Suicide 4 Homicide within 24 hours a 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 10, 2005 O 23a) (Type, Print) 30. Name and address of person who completed cause Wakun 111 Penn Street, Baltimore, Maryland 21201

Registrar

State

31. Date filed (Month, Day, Year)

JAN 2 6

2005

			For State Registrar	State of Mary	land / D	epartment Certificate	of He	ealth and eath	Mental Hy	giene Reg. No.	200	5 01911
	Dhyaiai		Decedent's Name (First, Middle, Las	t)					2. Date of De.		2 C Year	3. Time of Death
	Physicia /Medic			0 -	Seaman				January			8:20am м
j.	Examin	er	4a. Facility Name (If not institution, give Fairhaven Health		r		own, or l esvi	ocation of Deat	h		County of Dear	tn
	Funeral		5. Social Security Number 6. S	ex 7. Age (Ir	yrs. last birth	day) If Under 1	1 Year	If Under 24 Hrs		h Voar	9. Bin	thplace (State or Foreign
	Director		200 00 /0/2	¹ X ^{M 2□ F} 98	3 Y	rs. Months	Days	Hours Min.	Aug 1,	190	6 X	puntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location			-			10d. Inside City Limits
	Mary a-f she	tor	MD Carro	11	Sy	kesvill	e					1 ☐ Yes 2 ☐ No
	ith the	Director	10e. Street and Number			10f. Zip (10g. Citi	zen of What Co	ountry?
	s 23a		7200 Third Aven		- :- 110		1784				USA	siana Indian
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	/ Funerai	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 Y Yes 2 1 No 1 Yes, Give 1 0		If Yes, speci		panic Origin? (s , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Black, Whit	e, etc.
5-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates: 15		Decedent's Usual		ion		16h Ki	nd of Business	
<u>.</u>	n nai	piete	(Specify only highest gra	de completed) College (1-4or 5+)	1 (Give kind of work life. DO NOT use	k done du	iring most of wo	rking	TOD. KI	nd of business	industry
77	ad with giene er the	Completed	Elementary/Secondary (0°12)	4		Banker					anking	
yland	be file	Be	17. Father's Name (First, Middle, Last) Charles Keen	Seaman					me <i>(First, Middl</i> e, Francis		•	
<u></u>	should nd Mer marke matic	P	19a. Informant's Name/Relationship (1		19b. I	Mailing Address	(Street ar	, ,	ural Route Numbe			Zip Code)
Z Z	alth ar 27 is		Mr. Robert L. Hut	• • • •	utor)	2809 St	i11 :	Leaf La	ne Elli	cott	City,	MD 21042
saltimore,	es 1 a of Hei of Hei of othe	100	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	20b. Place of to cemetery	Disposition (Nam, crematory or ot	e of her place,	,	Date	20c. Lo	cation - City or	Town, State
Ě	. Pag tment tent: I		' 4 ☐ Donation 5 ☐ Other (Specify)	A11 Cοι	inty Cre				-	esville	
n n	Departition Department Importment			Hurt		HAIGHT Sykesv	FUN ille	ERAL HOI	ME & CHA 784 (410	PEL.)-79	PA (Bo 5-1400	x 195)
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the	death. Do no	ot enter the mode	of dying,	such as cardia	c or respiratory as	rest,		Approximate Interval Between Onset and Death
1	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a Atheras	-		3-5-	1-14 V	41 6-1-	U.	さいす	15715
	/Medical Examiner		1	Due to (or as a co	onsequence of	f):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of	f):						
	acuted ind transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c								
8/60,	cate be executed physician and the burial-transit		resulting in deathy East	Due to (or as a co	onsequence of);						
ρΩ		edicai		. d								
XOD	death certifi e attending d for use as	cian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3 □Ectopic pre	gnancy			2	23d. Date of del	
o n		Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown		5 ☐ Other (spe	ecify)				Month	Day Year
7.	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions c				use giver	in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
ğ	w requires t been signe should be		Dementin -	11-14:-	Inf	· < /			1 🗆 🗅	/es 2[JM6 3□Pr	obabły 4 ⊡Unknown
Hecord	e lawr has be je 2 sh	ompieted							24a. Was autop		24b. Were at prior to death?	topsy findings available completion of cause of
	Th ate pag	O							1 ☐ Yes	2√Z No		2 No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 □ ER/Outr	patient 3☐ DO/			ath <i>(Check only o</i> Home 5 ☐ Resid		S ∏Other (Soe	cify)
TO L		T:Ľ	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Ye	28b. Tii		Bc. Injury a	at	28d. Describe I			,,
S	Attending r death. sctor: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2□No	Ont Leasting (74	d Missola a a a D	
DIVISION	or At after of Direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (5	- At nome, fari Specify)	n, street, factory,	Office		City or Tox	vn, State)	ural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fr	edical C		ysician: To the best of mainer: On the basis of exa								
	thin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner stated			License				e signed (Mont	
	Z <u>X</u> Z S		Road J.	Moro,	MO		03	288	2	//	73./	38
6	10		30. Name and address of person who	completed cause of death	n (Item 23a) (T	Type, Print)		" Ca	- 6 1	2.	Reint	Sofor Mil
	Sta Registr		31. Date filed (Month, Day Year)	32. Regis r's	Signature	, ,	A					
					5-8- J	A Page	50					

		1-	For State Registrar		Sta			d / Dep		t of H	ealth a		ental Hyg	_	005	0191
Physici /Medic			Fred L	e (First, Middle, ouis Se	more								2. Date of Dea Month	Day,	žiss	3. Time of Death
Examir	ner			Arundel		ital	n /ln urn	ast birthday)		Glen	Burn	ie	0.00	Anı	ty of Death	
Funeral Director		2:	27-22-4 al Residence of	994	1 X M 2		77	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Apr. 4	, Year)	9. Birthp	place (State or Foreign htry) VA
the Marylan 28a-1 show Folified at	ctor		State MD	Anne A	Arunde	el	10c. City	r, Town or Lo	dentor	n					1	0d. Inside City Limits 1 ☐ Yes 2 XNo
ath with the 23e or 21	Funeral Director	10e.	703 Or	chard O					10f. Zip	2	1113			log. Citizen of	What Cour	ntry?
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Maryland 21215-0036 td 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other then "neturel", or treumatic event, the Medical Evanti	Completed	EI	(Spec ementary/Secon	15. Decedent's ify only highest ndary (0-12)	grade comp	pleted) llege (1-4or 5	+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us Trucl	rk done d se retired,	luring most	t of workin	g			Trucking
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Baltimore permit. Pages 1 Department of H Importent: If ite any injury or ot		_		5 Other (Speneral Service Line)		asse	me	22	. Name an	d Addres	s of Facility Sons Sitch:	v	A. Seve		more, irk Fu irk, M	neral Home D 21146
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rds, P quires that n signed b	by	Part	II. Other signifi	cant conditions	contributin	ig to death bu	it not resu	lting in the u	nderlying ca	tuse give	n in Part I.			es 2 No	tribute to th	e cause of death?
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on of ding Phys h. After this funeral di	Certification: To Be	27. N	Was case referr examiner? Yes 2 1 Man or of Death Natural Accident	No 5 Pending investigat	on	1 Dinpatier Date of Injun (Month, Day		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r. 4 🗆 Nur	rsing Home	Check only only 5 Reside d. Describe ho	nce 6 🗆 Oth)
in Diriginal	Certific	4	Suicide Homicide	6 Could not determine	d 289.	Place of Inju building, etc.	. (Specify)						City or Town	, State)		Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical		Certifier (Check only one) Signature and	1 Certifying 2 Medical Ex	aminer: On	To the best of the basis of dimanner state	examinati-	vledge, death on and/or inv	estigation,	in my opi	nion, deatl	place, an	l at the time, da	tuse(s) and mate and place,	and due to	the cause(s)
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1271			ane and addre	ess of person who	CKS I	Registra	r's Signate	OI H	ospit	al C) vive	, Gle	en Bur	rnie M	1D, 2	1061
Sta Registr			JAI	2 6 20	05	Registra	. St.	Spa	de							

Seymore, fred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JAMES Jan 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMERE
If Under 1 Year If Under 24 Hrs. Agnes Healthcare 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs_last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 251-24-910 12 M 2□ F Months Days Hours Year) Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at Director 1XYes 2 □ No BALTIMORE WOODMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? or Items 23a DRIVE TARUBA USA 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. If item 27 Is marked other then "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 HEGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7021 VERNELL WIFE VATARUBA WOODMORE, MD. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or *4 □ Donation 5 □ Other (Specify) ARRISON FOREST 02-02-05 OWINGS HILLS 21. Signature of Funeral Service Licenses ULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ELectrolyte Imbalance 48 hrs /Medical Examiner Acute Renal 48 mrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 146 2 1 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2/No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P16695 23 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babatunde Sant Agner 900 Coton Avenue, Ral-

Registrar DHMH 17 Rev 1/2001

State

Sant Agnes

31. Date filed (Month, Day, Year)

32. Registar's Signature

Avenue

			1 - For State Registrar	State of Maryla	-	artmen	t of H	ealth a			giene	200		1.
			Negistrar Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		rimouri	5 01 1	Jean		2. Date of Dea	Reg. Not	-00	3. Time of Death	1.5
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	Funeral		Laurel Region 5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birth (Month, Day			irthplace (State or Forei	gn
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	anyla shov	-	10a. State 10b. County	106. (City, Town or Lo	ocation							10d. Inside City Limit	
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ital		BeC	25. Was case referred to medical					26. Place	of Death	Check on on	27		2010	
of <	Physic this ce al dire	To	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2[☐ ER/Outpatien	t 3[] DO	A Othe	r: 4 🗆 Nurs	sing Hom	e 5 🗆 Reside	ence 6	Other (Sp.	ecify)	
	Attending Physicien: r death. ector: After this certific. by the funeral director;	:uo	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	28	3d. Describe ho	w injury	occurred		
si Si	tendi leath. tor: A the fu	catl	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М		es 2 □ N	_					
Division	5 th 5 cm	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, tarm, str cify)	eet, factory,	office		28	St. Location (St. City or Town	reet and n, State)	l Number or F	Rural Route Number,	
Ц	pitel		29a. Certifier 1 Certifying Physi	icien. To the best of my kr	sowledge death	a conversed o	t the time	- data and	lalana ar	and office an above on				
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Z.	Me	29b. Signature and title of certifier	1.1.1			License			2:	9d. Date	signed (Mon	th, Day, Year)	
				rem of			DZ	728	3	1	124	1/2005		
Λ:	18		30. Name and address of person who gor	npleted cause of death (Ite	em 23a) (Type,									
رر			M. Yusuf 13631	Baltimore	Avenu	e, La	aure	1, M	ary	land,	207	07		
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	Registr		Inn Ch	TITLE AND AND AND ADDRESS OF THE PARTY OF TH	1									

			1 - For State Registrar AMEND ITEM	State of Maryla #7& PER THE C				Mental Hygie	2000	01915
	Physici /Medi		1. Decedent's Name (First, Middle, La.		040 2/2	.0/U) Jh		2. Date of Death Month	Day Year	3. Time of Death
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	Funeral Director			ex 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	1926 9. Birtl	nplace (State or Foreign untry) MD
	the Maryland r 28a-f show notified at	ctor	10a. State 10b. County N/A	10c.	City, Town or Lo Bal	cation fimore				10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28 ust be not	ai Director	10e. Street and Number 5422 Adding	on Road		10f. Zip Code	21229	10g.	Citizen of What Co	untry?
036	hin 72 hours after death with the Maryland B. an "natural", or Items 23a or 28a-f show Medical Examinations Ler moilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1	1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2万No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: 12	
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	V To I	×	29b. Signature and title of certifier	lin Mi)	29c. License		29d. C	ate signed (Month,	Day, Year)
	\		30. Name and address of person who defects the second seco	ST AGNO	em 23a) (Type, P	O CATO	NAVE	BALT.	MD 21	229
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 2 6 2	005 32. Floistrar's Sig		me				

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	Physici	ian	1. Decedent's Name (First, Middle, Las	")							2. Date of Death Month	Day	Year	3. Time o	
	/Medi	cal	Melva Salvo		h1		41. Oh. T		1 111		January		005	2:25	Ам
	Examir	ner	4a. Facility Name (If not institution, give 3921 Innerdale Ct		oer)				Location of 1stow			4c. County	of Death Limor	~	
	Funeral		5. Social Security Number 6. Se		. Age (In yrs.	last birthday)	If Under 1	Year_	If Under 2	24 Hrs.	8. Date of Birth (Month, Day,			place (State	or Foreian
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation							Od. Inside C	Sh. I inite
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	r dea	ner	11. Marital Status	12. Was Deced Armed Forc		.S. 13. \	Vas Decede Yes, specif	nt of His y Cubar	spanic Orig	in? (Spe	ecify Yes or No- Rican, etc.)	14. Rad	ce - Ameno ck, White,		
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land		Be	17. Father's Name (First, Middle, Last) Charles Haman						_		(First, Middle, M	laiden Suman	ne)		
3	2 should be and Mental is markad aumatic ev	은	19a. Informant's Name/Relationship (T	nn Drink		1401 14 77		0			arish				
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a	permit. Departm Importa any inju		21. Signature of Funeral Service Licens		1	22	Name and	Address	1	_	Home P.		,	7	
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			23a. Part1. Enter the disease, of companies shock, or heart failure. List only of	ne cause on eac	ised the deat th line.	h. Do not ente	or the mode	of dying	, such as c	ardiac o	r respiratory arre	st,		Approximat Interval Bet	ween
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	/Medical Examiner		resulting in dealiny	Due to for	as *conseq	uence of):	21 8	m (7	1,0-				
	*	<u>ة</u>	Sequentially list conditions. if any, leading to immediate	Due to (or	as a conseq	uence ot):	0	, 00		2 ,	11/20	Con	8		
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Ď,	e exectian an		resulting in death) Last	Due to (or	as a conseq	uence of):									
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5	ding th. After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	M 200	Linjury a Work?	at es 2.⊟Ne		8d. Describe how	injury occurr	90		
2	Atten r dea actor by the	ifica	3 Suicide 6 Could not be	28e. Place of	Injury - At ho	ome, farm, stre		-		_	8f. Location (Stre	et and Numb	er or Rurai	Route Num	ber,
5	s afte	Certification;	4 Homicide determined	building,	, etc. (Specif)	/)					City or Town,	State)			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only cont) (Check only cont)	sician: To the be	est of my kno	wledge, death	occurred at	the time	, date and	place, a	nd due to the cau	se(s) and ma	nner as sta	ated.	
	tha I	Med	one) 29b. Signature and title of certifier	and manner	stated.										
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	Registr	ar	JAN 2 6 2005	Receive	J.	Coarle	1					2	-17.	77	

Amend Items 23a, PtI, 28a, b per Dr. C839, 0126/05dhb

Amend Items 23a, PtI, 28a, b per Dr. C839, 0126/05dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 20, Year **Physician** 2005 Emma Jane Sanford 3:30 A M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplece (State or Foreign Country) 1922 Ohi.o 8. Date of Birth (Month, Day, Year) June 18, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 200 F 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or than "natural", or itema 23a or 28a-f ahow the Modical Exeminer must be notified at 1 Yes XXX Director Maryland Prince George's Forestville: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 2612 Lorring Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 12 should be filed who and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Oliver Manilla Johnson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code s 1 and 2 sh of Health and item 27 is m 2612 Lorring Drive, Forestville, Maryland 20747 Susan Sanford (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 25, Data 2005 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of P Important: If its any injury or of N ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cemetery Suitland, Maryland 21. Signature of Funeral Service Licenseg 22. Name and Address of FacilityLee Funeral HOme, Inc 6633 01d Alexandira Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hypoxi CL se o (or as a consequence of): 18 Lours disease or condition resulting in death) /Medical Examiner Treumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit Pleural effusion and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria **Encephalopathy** Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Lemen tia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☼ No 24a. Was an has autopsy performed? 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٤ 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Division 1 X Natural 3.30A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 05793 20 M.D. , Ph.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7543 Surratts Road, Clinton, MD 20735 Lirong Lhao 31. Date filed Month, Day, Year) 32. Registrar's Signature State Sparke Registrar

ORIGINAL

DHMH 17 Rev 1/2001

JAN 2 6 2005

State of Maryland / Department of Health and Mental Hygien 2 0 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** JOHN HENRY SHACKELFORD JANUARY 21, 2005 8:00P /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner BALTIMORE 7132 GREENBANK ROAD MIDDLE RIVER 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign M 2□F 87 MARYLAND 215-07-1707 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 17 is marked other than "naturel", or Iteme 23a or 28e-f shor traumatic event, the Medical Examanar must be notified at MD BALTIMORE MIDDLE RIVER 1 Tes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7132 GREENBANK ROAD 21220 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:WHITE 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL FOREMAN BENDIX 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be 1 nent of Health and Mental I ent: If Item 27 is merkad o DAVID EUGENE SHACKELFORD SOPHIA (FRITZSCHE) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7132 GREENBANK RD.MIDDLE RIVER, MD. 21220 CAROLYN HINCHLIFFE / DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State METRO CREMATORY permit. Pages Department of I Importent: If Its eny Injury or o once. 1 ☐ Burial 2XX cremation 3 ☐ Removal from State 1-26-2005 Catonsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MARYLAND 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC ADENOCARUNOMA Physician 2 MO /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After To the Hospitel or Attending 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lugenells als D0044018 MO 6565 N. Charles St. 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fugene A. Obah GRM GBMC Eugene Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 2 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2135 M Leilani Simcox JANUARY 21 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SANDY SPRINCE BROOKE GROVE REHABILITATION AND NURSING CONTE MONTGOMERY tf Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Hawali 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year, July 31, I 7. Age (In vrs. last birthday) 1 □ M 2 🗓 F 570-72-9052 86 Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20874 13205L Cloppers Mill Drive United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Btack, White, etc. 1 ☐ Yes 2 No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Midowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Tomlinson (not available) Kanui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen N. Amos /Daughter 13205L Cloppers Mill Drive, Germantown, MD. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Arlington, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service-Vicenses 22. Name and Address of Facility. Obert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) INFARCTION MYOCARDIAL MINUTES Due to (or as a consequence of) VENTRICULAR SPOR MINUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of)

Pnysician /Medical Examiner

attending physician and for use as the burial-transit

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The law requires that the death certificate be executed

To the Hospitel or Attending Physicien:

Division of Vital Records. P.O. Box 68760.

nt of Heelth a : If item 27 is or other train

permit. Pege Department of Important: if any injury or once:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Items 23s or 28s-1 show

Baltimore, Maryland 21215-0036

nd other then "naturel", or items 23s or 28s-f show event, the Madical Examinar must be notified at

dical Exar	that initiated events resulting in death) Last	Due to (or as a consequence of): d.	
hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Completed by PI		Contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
Bec	25. Was case referred to medicat	26. Place of Death (C	
0	examiner? 1 ☐ Yes 2 No	He se iteli	5 ☐ Residence 6 ☐ Other (Specify)
ation; 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No	I. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
cal	29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29c. License number

GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

D42046

29d. Date signed (Month, Day, Year)

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

STAFF PHYSICIAN

			For Stata Registrar	State of	Maryland		artment of F				jienę	005	019	20
	Dhysisi	an	1. Decedent's Name (First, Middle,	Last)		-			2	. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medic			tevens						anuary	24,	2005	15:30	М
	Examin	er	4a. Facility Name (If not institution, Shady Grove Ad	-			4b. City, Town, o Rockv		of Death			county of Death		
_	Funeral	-			Age (In yrs. last	birthday)	If Under 1 Year		24 Hrs. 8	. Date of Birth	1	ntgomer	y nplace (State o	or Foreian
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	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	'our or Lo	cation		•					
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200	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event. Its Marked Examitize must be multified at	ed b	3 Widowed 4 Divorced 15. Decedent's	Year or Date		6a Decer	dent's Usual Occup	ation			16h Kind	d of Business/I	ndustry	
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מומ	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Name (i	First, Middle, i	Maiden S	lumame)		
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Ĕ	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationshi Edward R. Burde				Tatala				-			70
บ์	t and Health tem 27 other to		20a. Method of Disposition	cce/Filend	20b. Plac	e of Dispo	Latakia sition (Name of		Dat			Mary La ation - City or 1		/ 0
<u> </u>	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		ate		natory or other plac Ln Cemete:		Jan. 29 2005	9,	Brent	wood, M	farvlan	d
Saltimor	pernit. Pages 1 an Deportment of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service L					,						
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5	e exec ian ar urial-ti		resulting in death) Last	Due to (or	as a consequen	ce of):								
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0 X 0	death certific attending p	/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy	, <u> </u>					23	d. Date of deliv	(OD)	
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5	y Phys er this eral di	-	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of	Injury 28	Outpatien b. Time of	28c. Injur	/ at		d. Describe ho		Other (Specioccurred	ify)	
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<u> </u>	r Atte er de recto by th	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Flace of	Injury - At home , etc. (Specify)	, farm, str	eet, factory, office		28	Location (St City or Town	reet and i	Number or Rur	al Route Numi	ber,
5	ital o							****						
	Hosp 24 hou Fune Fune	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the be xeminer: On the basi and manner	is of examination	dge, death and/or inv	occurred at the ting vestigation, in my o	ne, date an pinion, dea	id place, and ith occurred	d due to the ca at the time, d	ause(s) a ate and p	nd manner as : lace, and due !	stated. to the cause(s))
	To the Hospital or Attending Physicien: within 24 hours after deals and the form of the Funerel Director. After this certific completely filled in by the funeral director, completely filled in by the funeral director,	Mec	29b. Signature and title of certifier	and manner	, stateU.		29c. Licens	e number		2	9d. Date	signed (Month,	Day, Year)	
	->-0	1	V, n	1			74	181	17		Tan	e.c. 74	700	-
1	0 (30. m and address of person w	no completed cause	of death (Item 23	Ва) (Туре,	Print)	, 0 /	/	9	-10100	eer 24	, 200	2
	0		Shahyar Gharach				al Cente	r Dri	ve, Ro	ockvil]	Le, M	aryland	1 20850)
	Sta Registr		31. Date filed (Month, Day, Year)	0000	istrar's Signature		9 10							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** January 20 9:45 a M STEWART GRACE W. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD CO ABERDEEN 22 E. BELAIR AVENUE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN 1 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 200 MARYLAND 89 Director 219-20-8902 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Mudical Examinar minist be notified at 1 ☐ Yes 2XXNo **ABERDEEN** MARYLAND HARFORD CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 E BELAIR AVENUE 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ★XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: BLACK δ 3€XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) APG PRODUCTION WORKER-1 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALICE BARNES JOHN BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 CHESTNUT ST, ABERDEEN, MD 21001 Clarence J Barnes/Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. *4 ☐Donation 5 ☐ Other (Specify) ST JAMES CEMETERY 01-26-05 HAVRE DE GRACE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. reduen 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part Fricare disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adhero Sclerd
Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) Physician/Medical use as t ed by the attending I detached for use as IF FEMALE. 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No O 9 Unknown s been signed by the should be detach ۵. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page this certificate 1 Yes 2 No Vital Hospital or Attending Physician: rector, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 W Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA ŧ of 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fi investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIG Harre 5. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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		•	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 201	15 01922
	0		Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
	Physicia /Medic	al	Bessie Frances Simmons January 24, 20	
	Examin	er		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	rford 9. Birthplace (State or Foreign Country)
	Director		220-03-2482 1 M 2 F 82 Yrs. Months Days Hours Min. (Month, Day, Year) June 5, 1922	Maryland
	pur M	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	/ sho	٥		1 ☐ Yes 2 HNo
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show afte event, the Medical Examinar must be notitied at	Director	Maryland Harford Aberdeen 106. Street and Number 109. Citizen of W	hat Country?
	3a or	Ö	939 Gilbert Road 21001 USA	,
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black	- American Indian,
ထ္	after or Ite	Fu	1 Never Married 2 Married 1 Tes, Specify Coban, Mexican, Fuerto Rican, etc.) 1 Never Married 2 Married 1 Tes, Specify Coban, Mexican, etc.) 1 Yes 2 No Free Specify: Specify: Specify:	, White, etc.
21215-0036	ural',	d by	□ 3 Widowed 4 Divorced Year or Dates: TATATT	White
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (16b. Kind of Bus	iness/Industry
12	withi ene. than	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own	Home
b	Hyg other ent,	Be C		
lar	uld be Aenta rked tic ev	To B	Frank (unk) Chalone Bessie (unk) Cer	ny
Maryland	2 short		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S	
	and sealth n 27 ner tr		Dewey C. Simmons, Sr. / Husband 939 Gilbert Road, Aberdeen, Maryla	
Baltimore,	ges 1 t of H if iter or oth		1 Structure 2 Compation 3 Removal from State compatery, crematory or other place)	City or Town, State
ij	tmen tent: ijury		Bel Air Memorial Grdns. 1-29-05 Bel Air	, Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examination in the rollines at anone.		21. Sign the of Full of Survice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.	
		-	1317 Cokesbury Road, Abingdon, Ma: 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate
			fshock, or heart failure. List only one cause on each line. Immediate Cause (Final	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or any consequence of):	
	Examiner		Sequentially list conditions b.	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
80	and trans	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
8760,	cate be executed physician and the burial-transit	ical E	To the to (or as a consequence or).	
687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			
Box (nding use a	N/M	F FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date	of delivery
	death e atte id for	icia	in the past 12 months? 1	h Day Year
P.O.	es that the death certific igned by the attending p be detached for use as	Physician/Med	9 Unknown	
	es the	by	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	
Records,	w require been si should b	Completed	1 Yes 25No 3	B Probably 4 Unknown
Sec	ne law has b ge 2 st	nple	24a. Was an autopsy 27 pr	ere autopsy findings available or to completion of cause of eath?
E E	icien: The certificate rector, pag			Yes 2 No
Vital	Physicien: The rath is certificate har ral director, page	o Be	examiner?	
of		-	inpatient 2 Levoupatient 3 DOX 4 Nursing nome 5 Residence 6 Other	
ion	nding (tth. :: After e funer	atlor	Natural 5 Pending (Month, Day Year) Injury Work? Accident investigation M 1 Yes 2 No	
Division of	I or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	or Rural Route Number,
Ö	itel or A rs after et Directed in by	Cer	Summing, stat. (specify)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical	29a. Certifier Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, are	ner as stated. Id due to the cause(s)
	thin 2 the 3 the mplet	Med	one) and manner stated. ≥ 29b. Signature and title of certifier 29d. Date signed	(Month, Day, Year)
)	1 × 1 0		Hune San Can / D37364 Vinight	174 200t
•	141		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hong July Kim, ND	127,0003
	10,		19 wax nur Lane, Aberdeen, Hayang	
	Sta		a 31. Date filed (Month, Day, Year) 32. Registra's Signature	
	Registr	ar	JAN 2 6 2005 > Blown & Sparle	

05-00563 B.K.S JA'MAR M.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

A R	M. TAY	YLC	OR 1 - State Registrar	end Item	State of Ma 4a&Unpend	irylan Item	d / Depa i 23a, Z Cen	rtment of I	lealth and per me G Death	Mental Hy	Giene Reg. No.	2005	019	923
	Physicia		1. Decedent's Nam	ne (First, Middle, La	TAYLOR					2. Date of De Month	eath 23,	2005 ear	3. Time of 0550	f Death A M
	/Medic Examin		4a. Facility Name (If not institution, giv	re street and number) YVIEW MEDI	CAL	CENTER		ORE CITY		4c.	County of Death	1	
	Funeral Director				Sex 1 CXM 2□F	e (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birth Cou	place (State of intry) MD	or Foreign
	Maryland	tor	Usual Residence of 10a. State	10b. County BALT	IMORE		y, Town or Loc	STATION					10d. Inside C	ity Limits
	h with the 23a or 28a sat be not	Funeral Director	10e. Street and Nu	AVONDALE	ROAD			10f. Zip Code	.222		10g. Citi	izen of What Cou	antry?	
3	filed within 72 hours after death with the Maryland Hygione. ther than "natural; or tlems 23s or 28s-f show int, the Medical Exam her must be notified at	þ	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \) If Yes, Give Year or Dates:			/as Decedent of I Yes, specify Cub	Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Amer Black, White Specify: BL		
>	s 1 and 2 should be filed within 72 hours theath and Mental Hygione. Item 27 Is marked other than "natural; other treumatic event, the Medical Exa	Completed	(Spec		ducation ade completed) College (1-4or 5	+)	(Give k life. D	ent's Usual Occup ind of work done O NOT use retire	during most of wa	orking	16b. Ki	nd of Business/l		
	2 should be filed and Mental Hygi Is marked other eumatic event,	To Be Co		(First, Middle, Last)			/ A		me (First, Middle				dispusable to the second
, Mai	and 2 sho lealth and I m 27 Is me her treums		LISA BU	JRMAN/MOT	** *	Jack B	735	N. AVONI	And Number or R		ORE,	MARYLAN	D 212	22
	t. Page rtment o rtent: If njury or		`4 Donation			29-05 MES A. 1	BAL	TIMORE,	MARYL					
3	Depa Impo any ii		23a. Park. Enter	the disease, or com	aplications that caused	lo the death	1	701 - 31 I	AURENS S	T. BAL	FIMOR		21217 Approximat	te
	Physician /Medical Examiner		strick, or hea Immediate Cause disease or condition resulting in death)	(Final on	a. Sudden U Due to (or as	nexp]		Death Ir	Infancy				Interval Bet Onset and	
	12 50	Examiner	Sequentially list or if any, leading to in cause (Disease or that initiated event	onditions, mmediate erlying r injury	b. Due to (or as	a consequ	uence of):							-
,	ate be executed hysician and he burial-transit		resulting in death)		Due to (or as	a consequ	uence of):							
.C. DOV	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the teached for use as the forms.	hysician/Medicai	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 🗆	Ectopic pregnanc Other (specify)	у		2	23d. Date of deliv Month	-	Year
623	w requires that been signed t should be det	by P	Part II. Other signi	ificant conditions	contributing to death b	ut not rest	ulting in the un	derlying cause gr	ven in Part I.		tobacco u Yes 2[se contribute to ☐No 3☐Pro	· ·	death? Jnknown
		Completed	05 Was							1 X Yes	psy ormed? 2 \(\sum \) No	24b. Were aut prior to co death? 1 X Yes	opsy findings impletion of c	available ause of
	Phys this ral di	ation: To Be	25. Was case refe examiner? 1 X Yes 2 2 27. Manner of Dea 1 Natural 2 Accident] No	Hospital: 1 ☐ Inpatie 28a. Date of Inju Found th. Date 1-23-05	ry I	€R/Outpatient 28b. Time of Injury	unk 28c. Inju	ner: 4 ☐ Nursing I ny at	Home 5 Res 28d. Describe	idence 6		nk	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide	Could not be determined	00 Disco of lois	c. (Specify	Y) •	et, factory, office		28f. Location (City or To	(Street and wn, State) , Mai	735 N.A ryland	al Route Num vondal	e Roa
	To the Hospital or A within 24 hours after To the Funeral Directory completely filled in by	Medical	29a. Certifier (Check only one)	Medicel Exa	nysicien: To the best miner: On the basis of and manner sta	examina		estigation, in my	opinion, death occ		date and	place, and due	o the cause(s)
	PER E	Z	29b. Signature and	in hi	, m. (>				C.M.E			AN. 24,	2005	
I,	Mil		30. Name and add	tress of person who	completed cause of d	eath (Item	1 23a) (Type, F	rint)				1001		

State Registrar 32. Registrar's Signature

Sparle

111 PENN STREET, BALTIMORE, MARYLAND 21201

2005

LING LI, M.D

31. Date filed (Month, Day, Year) JAN 2 6

				State of Mar					•		•		
			1 - For State Registrar	Glate of Mai	ylaria /		rtificate of		i Wentarriy	Reg. No	200	5 0	1921
			Decedent's Name (First, Middle, L.	ast)					2. Date of De	aath		3. Time o	of Death
	Physicia /Medic		Edward Vincent !	Thomas					Januar	р У 22	Year 2005	6:4	2 pm ^M
	Examin		4a. Facility Name (If not institution, g.	ive street and number)			4b. City, Town, o	r Location of De	ath	40	. County of Deal		
			Laurel Regional I				Laure				Prince G	eorge':	s
	Funeral			1 M 2 F	In yrs. last l	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	n. (Month, Da	rth ay, Year)	9. Birt	hplace (State	or Foreign
	Director		338-09-8454 Usual Residence of Decedent	XX 8	8	113.			Apr. 4	, 19)16 I11	inois	
	yland		10a. State 10b. County	1	Oc. City, To	own or Lo	cation					10d. Inside C	City Limits
	a-fsl	ctor	MD Anne A:	rundel	Lau	rel						1 ☐ Yes	s 2∏No XX
	or 28	Director	10e. Street and Number				10f. Zip Code	-		10g. Ci	tizen of What Co	ountry?	
	ath w		3565 Ft. Meade Ro				2072				J.S.A.		
	er de Itams	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces? 1XXYes 2 ☐ No		13. \	Was Decedent of H f Yes, specify Cubi	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	 Race - Ame Black, Whit 		
36	irs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2XXVo	Specify:			Specify: w	hite	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. khar than "natural; or Itams 23a or 28a-f show int, tha Medical Ever: it art mat be molified at	ted	15. Decedent's		16	Sa. Deced	dent's Usual Occup	ation		16b. K	(ind of Business/		
2	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	_College (1-4or 5+)			kind of work done DO NOT use retired	d) most of w	rorking				
7	ygien ygien ygien thar th			l year		So	ldier				. Army		
and	be fill had be fill had ott	Be	17. Father's Name (First, Middle, Las Edward Thomas	50)					ame (First, Middle Robertso		n Surname)		
ž	hould d Mei marki martic	To	19a. Informant's Name/Relationship	(Type Print)	11	Ob Mailir	ng Address (Street				Town Class	7:- 0-4-1	
<u>8</u>	od 2 s Ith an 27 is traus		William F. Thomas				e Beaulie		e, Belgi		7021	up code)	
ē,	s 1 ar f Hea itam		20a. Method of Disposition	,			sition (Name of natory or other place		Date		ocation - City or	Town, State	
9	Page: ient o nt: if ry or		1 ☐ Burial 2XXCremation 3 `4 ☐ Donation 5 ☐ Other (Spec	LI TIGITIO VALITIONII SIAIG			l Cremato		6/2005	Ode	enton, M	aryland	đ
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked othar than "natural; or items 23a or 28a-f show any injury or othar traumatic event, the Medical Ever-item ast be pullful and once.		21. Signature of Funeral Service Lic	ensee		22	. Name and Addre	ss of Facility	Homo D	70			
m	9 9 1 8 8		1 GS G	/ MO	0770	3	13 Talbot	t Avenu	e Laure	1, M	Maryland	2070	7
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the one cause on each line.	ne death. D	o not ent	er the mode of dyir	ng, such as card	ac or respiratory a	rrest,		Approxima Interval Be	tween
	Enysician	e w	Immediate Cause (Final disease or condition					Onset and 1 -2 we					
	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	ce of):							
		7	Sequentially list conditions, if any, leading to immediate	b. Gastroi Due to (or as a			Bleedin	I				l day	
7	nsit	Examiner	Cause (Disease or injury	Atrial			ion					1 -2 we	o o le a
ੂੰ ਹ	execun and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a c			1011					1 -2 we	seks
3760, J	ate be executed hysician and he burial-transit	cal	•	d. Lung Ca	ncer							1_year	
8	ntifica ng ph as th	Medi	IF FEMALE:										
Box	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		ath 3	Ectopic pregnancy	,		1	23d. Date of del Month		Year
o.	it the death certific by the attending p tached for use as	/sici	1 Yes 2 No	4□Pregnant at tir 9□ Unknown	ne ol death	5	Other (specify) _				WORTH	Day	1 ear
۵.	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions	contributing to death but	not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did	obacco	use contribute to	the cause of	death?
ds,	uires tha signed I Id be det			, and the second	•		, , ,				□No 3□Pr		
Record	w requir been si should I	lete							24a. Was	an	24b Were au	topsy findings	available
Re	The lay	Completed								med?	prior to death?	completion of	cause of
Vital		a)	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only	ak xNo	1 ∐ Yes	2XXV0	
	S 0 70	To B	examiner? 1 □ Yes - ¾XNo	Hospital:	2 ER/	Outpatien	t 3 DOA Oth	00	Home 5 ☐ Resi		6 ☐Other (Spec	cify)	
0 [27. Magner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b	Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how inju	ry occurred		
Sio	Attanding ir death. actor: After by the fune	cati	2 Accident investigati	he				Yes 2 □ No					
Division of	or Attano after death Diractor; in by the	Certification:	4 Homicide determine	28e. Place of Injury building, etc.	(Specify)	tarm, str	eet, factory, office		City or To	Street ar wn, State	nd Number or Ru e)	ıral Houte Nun	nber,
_	e Hospitai 24 hours a a Funerai l letely filled		29a. Certifier 1 Certifying I	Physician: To the best of	mv knowled	loe, death	occurred at the tir	ne. date and pla	ce, and due to the	cause(s) and manner as	stated	
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Expone)	aminer: On the basis of each manner state	xamination a	and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date an	d place, and due	to the cause(s)
	To the within 2 To tha complet	M	29b. Signature and title of perting				29c. Licens	e number		29d. Da	te signed (Monti	h, Day, Year)	
) yell	>			D 00	59228		Jan	uary 24	2005	
	MAI	į į	30. Name and address of person miles				•						
	8	127	Elvira Pasmanik, 31. Date filed (Month, Day, Year)	22 Angietrar	e Signatura		Road #10	9 Laur	el, Mary	land	20724		
	Sta Registr		JAN 2 6 2		J	1	model						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year ANCIN INDERWOOD 23 2:55AM 12005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Home wood Baltimore If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) D4 - 26 - 1956 If Under 1 Year 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F 220.68.2597 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notfried at MD Baltimore 1 SeYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Street W. Franklin Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 K Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify: ۵ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service 12th grade 2 years 7 is marked other treumatic event, 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Simmons Underwood Dorothy Neldon ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 is 3511 W. Franklin Street Baltimore MD 21229 Marvin Underwood Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 Department of important: if it any injury or o once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01.29.05 Randallstown, MD King Tan 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Vaughn C. Greene Funeral Services 5151 Baitimore National Pike Baito. MP 21229 21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine physician end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending ph I for use as t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? certificate has b irector, page 2 sl 1 ☐ Yes 2 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address deperson who completed cause of death (Item 23a) (Type, Print) 82 N-EUGW

egistrar's Signature

2005

DHMH 16 Rev 6/95

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 🛛 🔝 🤚 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 2005 Vaphides January 22:59p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Interstate 70 East @Clear Springs X Washington Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 19, 1957 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director 165-52-4432 Usual Residence of Decedent se 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantal Hygiene.

of Health and Mantal Hygiene.

of Health and Mantal Hygiene.

other treumatic event the Mantal E 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA Completed by Funeral Director Cambria Summerhill 1√Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 1/2 Main Street 15958 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Vaphides Ruth Cherny ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Seger (Sister) 602 28th Street Windber, PA 15963 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State = 0 permit. Page Department of Importent: If any Injury or once. South Fork Cemetery 1-28-05 4 □ Donation 5 □ Other (Specify) South Fork, PA of Funeral Service Licensee * 22. Name and Address of Facility Charles O. Dimond Funeral Home, ennis Mucen 621 Maple Street South Fork, PÁ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hult /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been applied to the Funerel Director. burial-transit Due to (or as a consequence of): physician s the burial P.O. Box 68760, as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Nnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Compieted 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼es 2□ No 24a. Was an autopsy y performed? page 2 s 1 X Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ڴ Other (Specify) At Scene 28d. Describe how injury occurred vehicle that DINEY of a Wotor vehicle that 105t control 28a. Date of Injury (Month, Day Year) 12305 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Natural 5 Pending 2 Accident 3 Suicide 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Liver State 28f. Location (Street and Number or Rural Route Number, City or Town, State) Easthound I-70 filled in by 4 - Homicide Clearspring 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) **OCME** January 24, 2005 31. Date filed (Month, Day, Year) JAN 2 32. Regis ar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 05	U	19	6

			For State	State of Ma		epartment of F Certificate of				500	01921
			Registrar 1. Decedent's Name (First, Middle, Lass)	1)			Douin	2. Date of Dea	Reg. No.		3. Time of Death
н	Physici		7.2	´				Month	Day		
	/Medic		Jimmie Dear 4a. Fecility Name (If not institution, give		1	4b City Town	or Location of Dea	Januar		, 2005 County of Deat	9:00 P ^M
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0	Funeral Director			□M 2 X }F	89 Y	Months Davs	Hours Min	8. Date of Birt (Month, Day Aug. 27		4	hplace (State or Foreign untry) eorgia
	* *		Usuel Residence of Decedent		_09			Aug. 27	<u>و ۱</u>	10 00	eorgia
	yland		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then 'naturel', or Items 23a or 28a-1 show then 'naturel' has mailed Exercities and the notified at	by Funeral Director	Maryland Anne Aru	nde1		Odenton					1 X Yes 2 No
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	h wit	O E	705 Orchard Over1	ook Unit	102	21	113	:	Uni	ted Sta	ates
	deatl	Jer	11. Marital Status	12. Was Decedent I		13. Was Decedent of I	Hispanic Origin? (Specify Yes or No-		4. Race - Ame	rican Indian,
9	or ite	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 200 N If Yes, Give	No	If Yes, specify Cub		no Hican, etc.)		Black, White	e, etc.
21215-0036	ours :	by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:			Specity:	Black
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2	filed withi Hygiene. other then	No.	4th			Counter			Bure	au of	Engraving
b	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	
<u>a</u>	Vid b	70	John Wo	oden			F1c	onnie		Jones	
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	os 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, the Medical Exercities mast be notified at		Theodore Jones/so	on	705	Orchard O	verlook	Unit 102	Ode	enton.	Marvland2111
ē,	of He of He r othe		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla		Date		cation - City or	
Ē	Pages nent of int: If It		1 XBurial 2 ☐ Cremation 3 ☐ I 1 4 ☐ Donation 5 ☐ Other (Specify)			coln Cemet		6/2005	Brer	ntwood,	Maryland
Baltimore,			21. Signature of Funeral Service Licens			22. Name and Addre	ess of Facility				
B	permit. Departn Imports any inju		Y Juanita R 4	10mas	M00957	22. Name and Addre Donaldson 1411 Anna	Funeral) & amoH ad Odeni	rema	atory, Maryla	P.A. nd 21113
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do no					Haryra	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lir	10.						Interval Between Onset and Death
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\sqrt{Z}	pet nsit	nine	cause. Enter Underlying Cause (Disease or injury	200 10 (0, 43	a consequence or						
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9	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE.	23c. If yes, outcome	of pregnancy						
Box	atten atten for u	lan	in the past 12 months?	1 Live birth	2 Fetal death	3 ☐ Ectopic pregnanc	у		23	3d. Date of deli Month	very Day Year
o.	the de	ysic	1 ☐ Yes 2 🎇 No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time or death	5 Other (specify)					
٩	that the	Ph	Part II. Other significant conditions co	ntributing to death by	ut not resulting in t	ne underlying cause an	(en in Part I	23e Did to	haccous	e contribute to	the cause of death?
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of V	nysic I dire	일	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3□ DOA Oth	er: 4 Nursing I	Home 5 Resid	ence 6	□Other (Spec	city)
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Vis	I or Attendi after death. Director: A I in by the fu	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At home, farm	, street, factory, office		28f. Location (S City or Tow	treet and	Number or Ru	rai Route Number,
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	spit hour mere y fille	ai	29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge,	death occurred at the til	me, date and plac	e, and due to the o	ause(s) a	and manner as	stated.
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Certification;	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination and/ ited.	or investigation, in my o	pinion, death occ	urred at the time, o	ate and p	place, and due	to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	100		29c. Licens	e number	2	9d. Date	signed (Month	n, Day, Year)
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			30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (To	/pe. Print)	11.00			-1.	11000
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T.	Sta	ite	Brian C. Wallace 31. Date filed (Month, Day, Year)	32. Re gis tra	âr's Signature	de Road B	altimore	, maryiai	iu Z	1230	
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	Funeral Director		5. Social Security Number 217-20-4604	6. Se	x XIM 2□F	7. Age (In	78 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, L July	irth Pay Yea L3	1926		place (State o ntry) y land	or Foreign
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.O. Box 6	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			irth 2 🗍 ant at time	Fetal death 3	Ectopic pr Other (sp							ate of delive		'ear
a	res that igned by be deta	y Ph	Part II. Other significant cond	itions co	ntributing to de	eath but not	t resulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use con	ntribute to th	ne cause of de	eath?
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Division of Vital Records,	nding Pt th. : After tt funeral	tion:	27. Manner of Death XXNatural 5 Pen 2 Accident inve	ding stigation	28a. Date (Moni	of Injury h, Day Yea	28b. Time of Injury	2 M	8c. Injury Work	at	- 2	28d. Describe					
ivisi	f or Attendi efter death. Director: A I in by the fu	Certification;	3 Suicide 6 Cou	-	28e. Place buildi	of Injury - /	At home, farm, str	eet, factory			-	28f. Location (City or To	Street a	ind Num te)	ber or Rura	I Route Numb	oer,
	To the Hospital or Attending Physician: whin 24 hours either date this 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certif	ing Phy	sician: To the	best of my	knowledge, death	occurred :	at the tim	e, date and	d place, a	and due to the	cause(s	s) and m	anner as st	ated.	
	the h	Medicai	Une)		and mani	ner stated.					71 0000716	o at the time,					
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		•	1 - For State Registrar	State of Marylan		artment o				giene Reg. No. 20	05	01	929	
	Physici	212	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ath Day	Year	3. Time o	f Death	
	/Medic		MARY ELLA WRIG						January	7 15, 20	05	5:32	2 рм	
	Examin	er	4a. Facility Name (If not institution, give s				m, or Location	of Death		4c. County				
			Laurel Regional Hos 5. Social Security Number 6. Sex		ast hirthday)	Laur		er 24 Hrs.	8 Date of Birti	Princ				
	Funeral Director			M 2∏ F 88	Yrs.		ays Hours		8. Date of Birth (Month, Day July 26	, Year) , 1916	Virg	ace (State try) Jinia	or roreign	
	laryland show	o.	10a. State 10b. County		/, Town or Lo						10	od. Inside C	City Limits	
	the N	Directo	Maryland Prince Ge	eorge s be	eltsvi	10f. Zip Coo	de			10g. Citizen of V	/hat Count			
	3a or	١	5310 Brewer Road			2070				U.S.A.		•		
36	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or Hems 23a or 28a-f show event, the Medical Examinar must be notified at	Completed by Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2XXVo If Yes, Give	1	Was Decedent I Yes, specify (ecify Yes or No- Rican, etc.)	14. Race Blac	- America k, White, e	etc.		
ë	hours tural'	q pe	37. Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a Decor	dent's Usual Oc	nounation				B1	Lack		
21215-0036	in 72 n "na nedic	plete	(Specify only highest grade	completed)	(Give	kind of work do DO NOT use re	one during mo	st of worki	ng	16b. Kind of Bu	siness/ina	ustry		
212	d with giene. rr thai	lmo	Grade 8	College (1-4or 5+)	Tes	ter				General	Elec	tric		
g		Be C	17. Father's Name (First, Middle, Last)			_	18. Moti	her's Name	(First, Middle,	Maiden Sumam	ө)			
<u>X</u>	2 should be and Mental Is marked o	To	Landon Greene				Mary	Payn	ie					
Maryland	12 7 F	1 7	19a. Informant's Name/Relationship (Type Karen A. Green / Gr							r, City or Town, . eland, N		,	08360	
altimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 X Xurial 2 Cremation 3XX	amoval from State	emetery, cren	sition (Name o	place)		Date	20c. Location -				
	artmer artmer ortent injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License							Fairfie	ld Tw	sp.,	NJ	
eg B	Dep Impe		21. Signature of Funeral Segrice Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland											
	Prrysician	¥ 10	23a. Part1. Enter the disease, or combine shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line. Myocardial			dying, such a	s cardiac o	r respiratory arr	rest,		Approximal Interval Bet Onset and	tween	
	/Medical Examiner		resulting in death)	Due to (or as a consequ										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)										H-1	
1	rcuted nd transit	Examiner	cause. Enter Undertying Lause (Cisease of injury that initiated events resulting in death) Last Due to (or as a consequence of):											
8760,	cate be executed obysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	uence of):									
687	ificate g physas the	edic							_					
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and takes as should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2XXNo 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregna Other (specify				23d. Date Mon	of deliver	•	Year	
٥.	res that the de igned by the be detached	by Phy	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	nderlying cause	given in Part	1.	23e. Did to	bacco use contri	bute to the	cause of	death?	
ords	w require: been sig should b								1 🗆 Y	es 2 No	3 Proba	ibly 4 🗆	Unknown	
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/ita	iicien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						(Check only or	ne)				
ot	Physi this c	. To	1 ☐ Yes 💥 No	7.2	ER/Outpatien	t 3 DOA	Other: 4 N			ence 6 Othe		!		
O	Attending Physicien: r death. sctor: After this certifica	tion	XXNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	1	Injury at Work? 1 🗀 Yes 2 🛭		zed. Describe n	ow injury occurre	90			
Division of		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, offi	ice	2	28f. Location (S City of Town	treet and Numbe n, State)	or or Rural	Route Num	nber,	
	To the Hospitel or within 24 hours affer To the Funerel Dir completely filled in	edicai (29a. Certifier 1 X Xertifying Phys (Check only one) 2 Medicel Examin	icien: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the restigation, in m	ie time, date a ny opinion, de	and place, a	and due to the cood at the time, d	ause(s) and mar late and place, a	nner as sta nd due to	ted. the cause(s	5)	
	To the H within 24 To the Fi	Me	29b. Signature and title of pertitier	1)	29c. Lic	ense number		2	9d. Date signed	(Month, D	ay, Year)		
,			Three	My &			00142	52		January	y 17,	2005	- 7	
_	6		30. Name and address of person who con	B-190	leest	Print)	SD	73	13 0	See 30	MA	PK	201	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 20	32. Resider's Signal	ture	haile		-1					. ,	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend item I per doctor 8842 4-14-05 vt
State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sv1vester Linwood Wall Day Month **Physician** 24 Sylvester Bernard Wal: January 2005 1:35 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. Genesis Elder Care Homewood Center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 XM 2 ☐ F Months Days Hours Director 08/14/1948 212-46-2294 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral', or Itams 23e or 28e-f show Examinar roust be notified at 1 TyYes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 Laurens Street 21217 . A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic evant, I've Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) is marked othar than College (1-4or 5+) Culinary 11 Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Menta! I ant: If item 27 is marked o Linwood B. Wall Christine Wiggins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Little / Sister 516 Tunbridge Road, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 01/29/2005 Landsdowne, Maryland 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? þ ed bluods 1 Nes 2 🗆 No 3 ☐ Probably 4 ☐Unknown Completed 245. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate 2**C** 1 Yes or Attending Physician: Be 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Desiring Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 21 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending death. investigation 1 | Yes 2 No s after death. 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 2 gistrar's Signa State Registrar

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death					
	Physic /Medi		1. Decedent's Name (First, Middle, Last) A vvc t t	e Willin	tms	2. Date of Death Month	Day Year 3. Time of Death 2 2005 1015 P M
	Examir Funeral	ner	5. Social Security Number 6. Sex	nons Nursing Home	y) If Under 1 Year If Und	der 24 Hrs. 8. Date of Birth	Baltimore 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 286 45 Yrs		S Min. (Month, Day, Yea 03 · 28 · 1	959 MD
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or Items 23e or 28e-f show eny injury or other treumetic event, "the Medical Examiner must be modified at once.	by Funeral Director	10a. State 10b. County	Bal	timore		10d. Inside City Limits 1 ☑ es 2 ☐ No
			10e. Street and Number 2930 Cherry Lui		10f. Zip Code 21225	>	Citizen of What Country?
		d by Fune	11. Marital Status 1 Status 1 Status 1 Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ★No Specif		14. Race - American Indian, Black, White, etc. Specify: TSLACK
		To Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. De (G. (G. (G. (J. 4or 5+)	cedent's Usual Occupation five kind of work done during mi b. DO NOT use retired) Janitor	nost of working	Kind of Business/Industry athot Janiforial Service
			17. Father's Name (First, Middle, Last) Richard William	8		other's Name (First, Middle, Maide Velyn Thom (
			19a. Informant's Name/Relationship (Ty, Denise Ware /	sister 542	28 Masefield F	nber dedural Route Number, City Road Baltim	or Town, State, Zip Code) ONE MD 21229
Baltimore,	Pages 1 nent of He ant: If iten		20a. Method of Disposition 1		position (Name of rematory or other place)	ł .	Location - City or Town, State Ndalbteven, MD 24133
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens		22 Name and Address of Fac Vamphy C. Gireen	Service Funeral Service Ba	icus. Litimore MD 21229
	Physician	ţ	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do not a	enter the mode of dying, such a	as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		resulting in death)	Due to (or as a consequence of).	7 1102		773,
ds, P.O. Box 68760,		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of it jury that initiated events	Due to (or as a consequence of):			
			resulting in death) Last	Due to (or as a consequence of):			
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
		by	Part II. Other significant conditions con	9	underlying cause given in Pari		use contribute to the cause of death?
Records,		Completed		acteria Sefsis		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital		Certification: To Be Co	25. Was case referred to modical examiner?	ospital:	Other	1 Yes 2	
			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	Mursing Home 5 Residence 28d. Describe how inju	
			3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)
		edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	To the vithin to the company of the the the the the the the the the the	W	29b. Signature and title of certifier	B. TURAKHI	29c. License number D 3 6 9	42 JAn	ate signed (Month, Day, Year)
	K		30. Name and address of person who co	impleted cause of death (Item 23a) (Typ	e, Print) long 4 Rd. C	gforfille, M	ate signed (Month, Day, Year) Fluory 25, 2005 9 2/228
Ì	State Registrar 31. Date filed (Month, Day Year) AN 2 5 2005 32 Registrar's Signature						

Amend item/17,19b, perFH_C839, 1/26/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21 Year **Physician** ROSANNA WILSON JANUALY 205 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD MED. CHESAPEAKE CENTER REL AIR If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) I Security Number **Funeral** Months Days Hours Min. 1 □ M 2 💢 F Director aryn Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f ehow other treumatic event, the Medical Examiner must be notified at 1 os 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA or Items 23e Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Yes Specify: ð 3 Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use etired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iled within al Hygiene. College (1-4or 5+) ndairy (0-12) Maryland gther's Name (First, Middle, Maiden Sumame), (First, Middle, Last) Smithwick Pages 1 and 2 should be 1 nent of Health and Mental I sont: If item 27 is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1017 Informant's Name/Relationship (Type, Print) Department of Health an Importent: If item 27 is eny injury or other treu toxglove 20b, Place of Disposition (Name of cemetery, crematory or other p Baltimore, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee seral Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical use as IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🔀 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 25 No 1 🗆 Yes Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatuse and title of certifier music 30. Name and address of pers pleted cause of death (Item 23a) (Type, Print) 7018 HOLABIRD AVE BALTO, Nd RERMIND 32. F gistrar's Signature State Registrar

		¥	1 - For State Registrar	State of M		nd / Depa		t of H	ealth a				005	01933
П	Physici	an	1. Decedent's Name (First, Middle,	,							2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	NATHANIE		KEK						Oi	18	2005	13:10 PM
	Examin	er	4a. Facility Name (If not institution, Prince George!		cni t	a 1			Location o	of Death			unty of Death	,
	Funeral			6. Sex 7. Ag		last birthday)	If Under		If Under		8. Date of Birth		nce Geo	orge's place (State or Foreign ptry)
1	Director		248-48-8347	1X1M 2□F	70	Yrs.	Months	Days	Hours	Min.	(Month, Day, July 5,	1934		n Carolina
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Maryl f sho	tor	Maryland Prince	George's		pitol I		t c					'	1 ∑Yes 2 □ No
	r 28a	irec	10e. Street and Number		l ou	PICOI	10f. Zip				1	0g. Citizen	of What Cour	ntry?
	th witl	al D	1207 Nye Street				20	0743				U.S.	Α.	
	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "naturel", or Itams 23a or 28a-f show avant, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🏖 Divorced	d 1 ☐ Yes 2 [2]. If Yes, Give Year or Dates:	No		1 ☐ Yes 2						ecify:	
9	2 hou	ted t	15. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	tion			16b. Kind o	B1a of Business/Inc	· · · · · · · · · · · · · · · · · · ·
215	within 73 ene. than "n.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	5+)	(Give	kind of won DO NOT us	k done di e retired)	uring mosi	t of workii	ng			
7	e filed within Il Hygiene. other than vant, the Me	Con	6			Consti	cuctio						ads	
and	l be fil ntal H ed otl	To Be	17. Father's Name (First, Middle, La Josephus Walke:								(First, Middle, I	Maiden Sun	name)	
Maryland 21215-0036	should be nd Menta marked imatic av	L _O	19a. Informant's Name/Relationshi			19h Mailir	ng Address	(Street a			I Route Number	City or To	um Stato Zin	Codel
	nd 2 sulth ar		Mary E. Freeman								k, SC 29		wii, State, Zip	C009/
Jre,	s 1 a		20a. Method of Disposition		20b. P	Place of Dispo cemetery, cren					-		on - City or To	wn, State
ij	Page ment (ant: If ury or		1 Burial 2 □ Cremation 3 1 Union 1 □ Other (Spe		1	. Moria			1	1/25	/05	McCoi	mick,	SC
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic a once.		21. Signature of Funeral Service Li	Petting	or.	22 W	Name and Valker	Address Fur Mai	s of Facilit neral ln St	Home	e cCormicl	s SC	29835	
			23a. Part1. Enter the disease, or conshock, or heart failure. List of	omplications that caused nly one cause on each lin	the deat									Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (as										
Į.		er	Sequentially list conditions,	b. Ateles	a consequ	uanourus):	1 2001	7						
	cuted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c Cardia	i 1	Arrhy H	imias							
Ó	e exection ar	Exa	resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	dical	-=	a. Prosta	K	enrun	mh							
Box 6	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth 4⊟Pregnant at	2 Feta	Ideath 3□	Ectopic pre					23d.	Date of deliver	ry Day Year
P.0.	res that the de signed by the a be detached f	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		Juli 3_	TOTHER (Spe	ichy/						
	The law requires that the ate has been signed by the bage 2 should be detache	ру Р	Part II. Dther significant condition				nderlying ca	use give	n in Part I.		23e. Did tob	acco use c		e cause of death?
ord	w require been sig should b	ted	- Spinal think	see comy	murc	m.					1 ☐ Ye	s 2 🗆 No	3 Proba	ably 4 □Unknown
Vital Records,	has be	Completed						_			24a. Was ar autops	/	prior to con	osy findings available apletion of cause of
alF											perform	No No	death? 1 ☐ Yes	2□ No
Z.	ysician: The is certificate hadirector, page) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:		57/0		Dthe	~		Check onl one			
of	a th	n: To	27. Manner of Death	1 X Inpatie	у	ER/Outpatien 28b. Time of		c. Injury	4 LI Nui		ne 5 Reside 8d. Describe ho)
ion	ath. r: Attu	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day tion	(Year)	Injury	М		? es 2□N	No .				
Division	or Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin				et, factory,	office		2	8f. Location (Str City or Town		mber or Rural	Route Number,
Ω	urs aft													<u> </u>
	To tha Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical	one)	Physician: To the best of aminer: On the basis of and manner sta	examinal	wledge, death tion and/or inv	estigation,	in my opi	nion, deat	d place, a h occurre	d at the time, da	te and plac	e, and due to	the cause(s)
	To vith	2	29b. Signature and title of certifier				29c.	License	number	16 61			ned (Month, D	
	0	-	30. Name and address of person wh	no completed acres of the	anth /lea-	23a) (T 1	Print'	9		770		'/		
	0		KALAI SELV					Hosp	ital	Dr.,	Chever	1y, M	D 20785	5
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2	005 Societa	ır's Signa	ture	will be							

el per mis

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>		of Health of Deat			giene	05	01021
	Physic /Medi		Decedent's Name (First, Middle, Last IRENE)	W	ACHTER			2. Date of Dea	ath)ď5″	3. Time of Death 4:00 PM
	Exami		4a. Facility Name (If not institution, give MILFORD MANOR NUR				wn, or Location	n of Death		4c. County BALTI	of Death	
	Funeral Director		5. Social Security Number 6. Se 215-09-0242 15	7. Age	(In yrs. last birthday) 94 Yrs.	If Under 1 Months	Year If Und Days Hours	er 24 Hrs. s Min.	8. Date of Birth (Month, Day SEP.17	, Year) 1910	9. Birthpl Count	ace (State or Foreign try) MD
	Maryland f show	tor	10a. State 10b. County	IMORE	10c. City, Town or Lo	Cation I MORE					10	Od. Inside City Limits 1 ☐ Yes 2 ☐ No
	sa or 28e	I Director	10e. Street and Number 4204 OLD MILFORD			10f. Zip Co	2120	no		10g. Citizen of V	What Count	try?
980	within 72 hours aftar death with the Maryland ene. than "natural; or itams 23a or 28e-f show i.e Modical Excenting must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Deceden If Yes, specify	t of Hispanic (Cuban, Mexic	Origin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - America k, White, e	
21215-0036	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene, item 27 Is marked othar than "natur othar traumetic event, tre Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use r RIETOR	done during m	ost of worki	ng	16b. Kind of Bu		ustry
Maryland	should be filed nd Mental Hygis s marked othar umetic event, the	To Be C	17. Father's Name (First, Middle, Last) AARON			ELSTEII	N TIL	LIE		Maiden Sumam	70)	FINK
	s 1 and 2 sho f Health and itam 27 Is m other traum		19a. Informant's Name/Relationship (Ty BEVERLY ROSENTHA 20a. Method of Disposition			SLADE A	AVENUE	#211	- BALTI	MORE, M	ID 212	Code) 208
Baltimore	permit. Pages Department of t Important: If its any injury or of once.		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		BETH YEHU	DA ANSI DA ANSI . Name and A	HE KURL	AND 1	/24/200 LEVINS	ON & BR	TIMOR	RE, MD
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	L	e death. Do not ent	er the mode of	f dying, such a	as cardiac o	r respiratory arr	TRESVIL		ID 21208 Approximate Interval Between Onset and Death
58760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Assess of Mury that initiated events resulting in death) Last	Due to (or as a o	consequence of):							
O. Box	death certifi e attending od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregn Other (specif				23d. Date Mon	e of delivery	/ Day Year
rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death but r	not resulting in the ur	nderlying cause	e given in Part	11.		_	ibute to the	cause of death?
al Record	The ate h page	Completed							24a. Was an autops perform	y pi ned? de	Vere autops rior to comp eath?	sy findings available oletion of cause of
Vital	Physicien: T this certificate ral director, pa	Be	25. Was case referred to medical examiner?	ospital:				e of Death	(Check only on	9)		
of	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No	1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatient 28b. Time of Injury	28c.	Other: 4 A Injury at Work?	2		nce 6 Othe		
Division	el or Attanding s after death. Il Diractor: After id in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)			1/1	8f. Location (Sti City or Town	reet and Numbe , State)	r or Rural F	Route Number,
	To tha Hospitel or within 24 hours afte to the Funaral Discompletely filled in	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or inv	occurred at the	ne time, date a my opinion, de	ind place, at	nd due to the ca d at the time, da	use(s) and man ite and place, ar	nner as stat nd due to th	ed. ne cause(s)
)	To tha within 2 To tha complet	2	29b. Signature and tifle of certifier	N	10	29c. Lic	cense number		29	Od. Date signed	(Month, Da	ay, Year)
1	1		30. Name and address of person who con	npleted cause of deat 5607 BACT 32. Registrar's	h (Item 23a) (Type, F	Print)	PIKE #	603 F	SALTIMUR	EMO	2122	-8
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature Joseph	1		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item#5, perful (840,2/4/05) 17
for Amend Trem 26 Right Magyaging Department of Health and Mental Hygiene? 1 1 5

/Medica	n	1. Decedent's Name (First, Middle, I	Last) Jeanet	tte We	itzel			2. Date of De. Month	Day / Y	3. Time of Dear
Examine		4a. Facility Name (If not institution, g		2011		4b. City, Town,	or Location of Death		4c. County of	Death
		410 Grier Nurs	erv Farms (74		Ctroo	.+		Harfo	
Funeral		5. Social Security Number 6.	. Sex 7. Ag	ge (In yrs. las	t birthday)	Stree	If Under 24 Hrs.	8. Date of Birt (Month, Da		Birthplace (State or For Country)
Director		212-10-8868	1□M 2♥F	88	Yrs.	Months Days	Hours Min.			Maryland
3	-	Usual Residence of Decedent 10a. State 10b. County		100 Ciby 1	Town or Loc	atio a				
ahow										10d. Inside City Lin
be netified	วี	Maryland Baltimo	re	Mic	ddle F	T				1 ☐ Yes 2 🙀
						10f. Zip Code			10g. Citizen of Wha	at Country?
ls 23	<u> </u>	3301 Iris Lane	12. Was Decedent	Francis II C	140.14	2122			USA	,
or Itams 23s	3	 Marital Status Never Married 2 Married 	Armed Forces?	7	IS. W	as Decedent of Yes, specify Cub	Hispanic Origin? (Sp van, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Hace - , Black, \	American Indian, White, etc.
al', or		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	110	11	□Yes 2√2 No	Specify:		Specify:	
ygiene. ner than "natural" t, the Medical Ex Completed h	בַ ב	15. Decedent's	Education			nt's Usual Occu	pation		16b. Kind of Busin	White less/Industry
	고	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4or 5		(Give k. life. Di	ind of work done O NOT use retire	during most of work	ing	rob. rand or basin	ood maasty
Hygiene. other than ant, tre Man	5	12	Oollage (1-401)	,+,	Claim	s Specia	alist		State o	f Maryland
I to E	D 1	17. Father's Name (First, Middle, La.	st)				18. Mother's Name	(First, Middle,	Maiden Sumame)	- Maryrand
	2	Joseph (unl	k) Noto				Elizabe	eth (ur	k) Klee	
th and Ment 7 Is markac traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Street	and Number or Rura	I Route Numbe	r, City or Town, Sta	te, Zip Code) 2115
4 7 2	L	JoAnn Lingner	/ Daughter							Maryland
of Healt itam 2 r othar	2	20a. Method of Disposition	_	20b. Plac	e of Disposi	tion (Name of tory or other pla	ca)	ate	20c. Location - City	
Int: If		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec	☐ Hemoval from State			f Faith	1-22-	.05	Polt imme	
Department of the function of		21. Signature 15 neral Service Lic		Gard	22	Name and Addre	ass of Facility uneral_Ho	.05	Baltimore	Maryland
Depa Impo any i	1	Mally U;	Heels		1	317 Coke	uneral Ho	me, P.A d Abin	adon Mar	yland 21009
		23a. Part1 Enter the disease, or con shock, or heart failure. List on	mplications that caused	the death. (Do not enter	the mode of dyi	ng, such as cardjac o	r respiratory ari	est,	Approximate
ysician i		Immediate Cause (Final	f-		10	Heart	Elis	~		Interval Between Onset and Death
Medical		disease or condition resulting in death)	a Due to (or 1)	estil		16001	141101			_
aminer			0	Umo,						
je je	5	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as							-
in and ial-transit		Cause (Disease or injury that initiated events								
an an rial-tr	1	resulting in death) Last	Due to (or as	a consequen	ce of):					
physician and s the burial-transit dical Examin	3		d							
ling physici e as the bu	3									
		F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			otonio nunna			23d. Date of	delivery
ag o	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			ctopic pregnancy other <i>(specify)</i>	·		Month	Day Year
0 0	-	9 Unknown	9□ Unknown					7.		
by the tached	P	art II. Other significant conditions	contributing to death be	ut not resultin	g in the und	erlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
gned by the attend be detached for us. by Physician/	3							1 □ Y	es 2 1 No 3	Probably 4 Unknow
en signed by the ould be detached ed by Physic	1 -							24a. Was a		autopsy findings availal
been signed by the should be detached etached leteched by Physi	-							autops	ned? prior death	to completion of cause of h?
been signed by the should be detached etached leteched by Physi	-						26. Place of Death	(Check only on		Yes 2□ No
been signed by the should be detached etached leteched by Physi	1 2	5. Was case referred to medical								Daughter
is certificate has been signed by the director, page 2 should be detached director. Page 2 should be detached.	2	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□EP/	Outpatient	3 DOA Oth	er. 4 Nureing Hon	1A 5 Daide	ALOG O LIOUNEI (S	Specific Residence
is certificate has been signed by the director, page 2 should be detached director. Page 2 should be detached.	2	examiner? 1 ☐ Yes 2 ☑ No 7. Manner of Death	1 Inpatie		Outpatient b. Time of	OLI DOX	4 Nursing Hor		w injury occurred	
is certificate has been signed by the director, page 2 should be detached director. Page 2 should be detached.	2	examiner? 1 ☐ Yes 2 ☑ No	28a. Date of Injur (Month, Day			28c. Injur Wor	4 Nursing Hor			
is certificate has been signed by the director, page 2 should be detached director. Page 2 should be detached.	2	examiner? 1 Yes 2 No 17. Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not	28a. Date of Injur (Month, Day	ry 28t y Year)	b. Time of Injury	28c. Injur War	y at k? Yes 2 No	8d. Describe ho	w injury occurred	r Rural Route Number,
biractor: Alter this certificate has been signed by the biractor: Alter this certificate has been signed by the trueral director, page 2 should be detached in by the tuneral director, page 2 should be detached rtification: To Be Completed by Physi	2	examiner? 1 Yes 2 No 17. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Date of Injur (Month, Day	ry 28t y Year)	b. Time of Injury	28c. Injur War	y at k? Yes 2 No	8d. Describe ho	w injury occurred	r Rural Route Number,
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05	-00120	dua	rdo Alvarez Please Type or P	rint in Black Ir	ndelible lnk.	Ensure All Copie	s Are L	egible.	
RF	D .		1 - For State of Registrer		partment of Hertificate of L	eaith and Mental F Death	lygiene Reg. No.	005	01936
	Physici		Decedent's Name (First, Middle, Last) Carlos Eduardo Alvarez			2. Date of Month Janua		2005	3. Time of Death 1012 A M
ř	/Medic Examin		4a. Facility Name (If not institution, give street and numb			Location of Death		ounty of Death	
			Montgomery General Hospita 5. Social Security Number 6. Sex 7.		Olney If Under 1 Year	If Under 24 Hrs. 8. Date of		tgomery	
	Funeral Director		None Usual Residence of Decedent	Age (In yrs. last birthda) 59 Yrs.	Months Days	Hours Min. (Month, 12/18)	Birth Day, Year) /1945	Uru	place (State or Foreign intry) guay
	aryland Bhow	_	10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits
	the Ma	ecto	MD Montgomery 10e. Street and Number	Silver	Spring 10f. Zip Code		10- Cities	en of What Cou	1 XYes 2 No
	3a or	i i	3204 Weeping Willow Court	#34	20906		Urus		indy?
	eme 2	inera	11. Marital Status 12. Was Deceder Armed Force			spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.)		I. Race - Amer Black, White	
9500-61212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelip and Mental Hygiene. Department of Heelip and Mental Hygiene. Introordent: If then 27 is marked other than "natural", or tieme 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.	d by Funeral Director	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 If Yes, Give Year or Date	XNo	1 X Yes 2 □ No	Specify: Uruguay		Specify: His	
7	in 72 h	ojete	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupa re kind of work done of DO NOT use retired	luring most of working	16b. Kind	d of Business/li	ndustry
7 7	d with giane.	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	atory Tecl		Med:	ical Fi	eld
Maryland	od othe	Be	17. Father's Name (First, Middle, Last)	•		18. Mother's Name (First, Mide		'umame)	
3	should and Me mark umatic	ဥ	Luis Alberto Alvarez Prev 19a. Informant's Name/Relationship (Type, Print)			Lilya Delia Mo		Town, State, Zi	p Code)
Ž,	and 2 selth e n 27 is		Maria del Huerto Gorski, V	life Pasa	je Asilo A	pt. 219, Motev	ideo,	Urugua	y 11600
saitimore,	If there or oth		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from Sta	20b. Place of Disp cemetery, cri	position (Name of ematory or other place	Date	20c. Loca	ation - City or T	own, State
	permit. Pag Department Importent: any injury once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		oln Cremat 22. Name and Addres	ory 01/11/2005			Maryland
n n	imped fimp		I along Won	uell 1	L040 Rockv	ille Pike, Roc	kville		and 20852
	Physician		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac Immediate Cause (Final	h line.		g, such as cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			as a consequence of):	(10)				
	pe is	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):					
, 90,	be executed iicien end burial-transil	ш	that initiated events	as a consequence of):					<u>-</u>
68760,	certificate be iding physicie ise as the bur	edice	d						
. Box	death e atter	Physician/Medical		h 2 ☐ Fetal death 3 It at time of death 5	□Ectopic pregnancy □ Other (specify)		_ 23	d. Date of delik	very Day Year
ري ت	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to deal	th but not resulting in the	underlying cause give	en in Part I. 23e. D	id tobacco use	e contribute to	the cause of death?
ğ	w require been sig should b	ted k					□Yes 2🏋	No 3□Pro	bably 4 Unknown
Rec	The law ate has b page 2 st	Completed by				p€	tas an utopsy erformed? s 2 \(\sum \text{No} \)	24b. Were aut prior to co death? 1 X Yes	opsy findings available ompletion of cause of
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	7.7.	ont all DOA Othe	26. Place of Death (Check on			
o	> .9 O	n: To	1 Xyes 2 No 1 Inline 27. Manner of Death 1 Natural 5 Pending (Month,		of 28c, Injury	at 28d. Descrit	e how injury	occurred	
Division	Attending Ir death. ector: After	Certification;	2 Accident investigation 1-5-05	a (18) and		res 2000 Pedestr	ian Stri	ick by	a motor vehill
<u>Š</u>	or Att	rtiffe	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	f Injury - At home, farm, s , etc. <i>(Specify)</i>	street, factory, office	28f. Locatio City or	n (Street and Town, State)	Number or Rui	al Route Number, AVE @ Connet i
_	To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	edicai Ce	29a. Certifier 1 Certifying Physician: To the b 2 Medical Examiner: On the bas	is of examination and/or	ath occurred at the tim	e, date and place, and due to t	he cause(s) a	nd manner as	stated.
	o the ithin 2 o the l	Med	one) and manne 29b. Signature and title of certifier	r stated.	29c. License			signed (Month	
	3		highi, mid		O.C.M			ry 6, 2	*
^			30. Name and address of person who completed cause	of death (Item 23a) (Type	111 Penn	Street, Baltim	ore, Ma	aryland	21201
F	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 1 2005	istrar's Signatur	Coule				

			State of Maryland / Dep		-	_	01937
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Death	g. 140.	01301
	Physici	an	Teresa M. Armentrout		Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	11, 2005 4c. County of Death	5:35 A M
	Exami	iei	Heritage Harbour Health & Rehab.	Annapolis		100	del County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign ntry)
	Director		578-16-8614 1 M 2 T 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Dec. 9,	1919 Aus	stria
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Marylis f sho	5		oution .			1 ☐ Yes 2 ☐ No
	the hours	Funeral Director	MD Anne Arundel Co. Deale 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	71
	3a or	Ö	669 Swan Drive	20751		U.S.A.	,.
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
ဖွ	after or Ite	E/	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2X No Specify:	Hican, etc.)	Black, White,	
21215-0036	72 hours after death with the Maryland Inaturel, or Items 23a or 28e-f show Lical Examiner must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:			Specily: Wills	
15-	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Business/Ir	dustry
77	withi iene. r than	ошр	Elementary/Secondary (0-12) College (1-4or 5+)	nemaker		Home	
	a fillec Il Hyg othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma		
/lar	uld be Venta Vrked Ific e	To E	Nikki Prezzi	Lina Lo	renzetti		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other than "naturel", or Items 23a or 28e-1 show any injury or other traumatic event, the Modeal Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Run	al Route Number,	City or Town, State, Zip	Code)
	l and fealth m 27 her tr		Linda Marie Bigley (Daughter) 669	Swan Drive, Deale			
Baltimore,	iges 1 nt of H if ite or ot		LALDUNAL 2 ICHMANON 3 Mamoval from State "	matory or other place)		Oc. Location - City or To	
ΕijΨ	it. Partmer			coln Cemetery 20 2. Name and Address of Facility Lee		rentwood, M	
Ba	permi Depa Impo any i			3125 Southern Mary			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
D	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	elicel Poster			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	ma juli	2		
	Examiner		Sequentially list aggriffices b Dellella				
	p 45	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	11			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death). Last C. Juliu to or as a consequence of:	ltoriue			
8760,	Attending Physicien: The law requires that the death certificate be executed reath. rectr. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ical E	Duedo (or as a consequence of):				
	ficate physics the	edic	d				
Box 6	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	erv
	death e atte	Icla	in the past 12 months? 1 Ves 2 No. 1 Live birth 2 Fetal death 3L	Ectopic pregnancy Other (specify)		Month	Day Year
O.	at the by th	hys	9 Unknown 9 Unknown				
	uires that the de signed by the a ld be detached f	by F	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ord	w requir been si should	ted	- IVOMIC ALLE		1 🗆 Yes	2 No 3 Prob	pably 4 Ulinknown
Records,	e law has b	Completed	,		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
	cate cate				performe 1 ☐ Yes 2	death? ¶No 1 ☐ Yes	2 🗆 No
<u> </u>	ysicien: The is certificate he director, page	Be	25. Was case referred to medical examiner? Hospital:	Other	(Check only one)		
of	Phys	1: To	1 ☐ Yes 2 ☐ Mo	IL 3 LI DOA 477 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Specify	1)
on	nding fith. :: After e funer	atlor	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	f 28c, Injury at Work? M 1 Yes 2 No		,,	
Division of Vital		iffice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		et and Number or Rura	l Route Number,
	tel or A rs after al Dire ed in by	Certification:	building, etc. (Specify)		City or Town,	Siale)	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or in and manner, stated	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as si	ated. the cause(s)
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and he of certifier	29c. License number		d. Date signed (Month,	
	- s + 0			D57028		anuary 11,	
	,		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	6	3	ADITYA CHOPRA, MD. 600 RIDGEL	4. Lug. Ste. 231. Ani	rapolis.	MD. 2140	
	Sta		31. Date filed (Month, Day, Year) 32. Registral's Signature	O .	7		
-	Registra	ar	JAN 1 2 2005 > Blocus &	HOBILES			

		ı	1 - For State Registrar	State of Maryl	and / Depa Ce	artment of He <i>rtificate of D</i>	ealth and Me Death		m 0 0 0	01938
	1		Decedent's Name (First, Middle, Last	et)		inioate of B		2. Date of Death	J. No.	3. Time of Death
П	Physici /Medic	31	Elizabeth	Ann A	bell		Ţ	Month anuary	Day Year 19, 2005	1:15 a.m.
	Examin	.6	4a. Facility Name (If not institution, give			4b. City, Town, or I		andary .	4c. County of Deat	
			22809 Washing	ton Street		Leo	nardtown		St. Ma	rv's
	Funeral		Social Security Number 6. Social Security Number		yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birt	hplace (State or Foreign
	Director		5/8-42-/1/9	7	O Yrs.			Mar. 19	1934 Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō	W 1 1 2	,		_	-			1∰Yes 2 No
	the 28a	Director	Maryland St. N 10e. Street and Number	lary's		Leona 10f. Zip Code	ardtown	100	. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28a-f ehow rmat be notified at		22809 Washingt	on Stroot			650			
	ms 2	Funerai	11. Marital Status	12. Was Decedent Ever		Was Decedent of His	panic Origin? (Spec	ify Yes or No-	United S	rican Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturat", or items 23e or 28e-f show atmatic event, if e.M. dical Examiner man be notified at	by	1 ☐ Never Married 2 ₹ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify Cuban 1 ☐ Yes 2 ♠ No	Specify:	ican, etc.)	Specify: Wh	•
ğ	2 ho	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupat	tion	16	b. Kind of Business/	Industry
212	thin 7	pie	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	uring most of working	9		
2	gd wil	50	12			Homemal	ker		Own Home	
9	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	uiden Sumame)	
Z a	should bind Ment s markac umatic e	မ	Thomas McGuire	*			Marg	garet Ma	ry Brown	
Jai	ges 1 and 2 should t of Health and Men If itam 27 is marks or other traumatic		19a. Informant's Name/Relationship (7	•					City or Town, State, Z	•
	1 and 1 Health am 27 other tr		B. Kennedy Abell, 20a. Method of Disposition	Jr./Husband	P.O.	Box 563,	Leonardto			
Baltimore,	Pages nent of H int: If its iry or of		1 € Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	matory`or other place)		c. Location - City or	
量	it. Pag rtment rtant: I njury o		'4 □ Donation 5 □ Other (Specification of the Control of the Cont		St. Aloy	sius Cem.	1-22-2	2005 <u>Le</u>	onardtown	, Maryland
Ba	permit. Page Department Important: I any injury o		Edward N. Brinsfi	leld Jr. MO	00052 2	2955 Holly	ywood Road	l, Leona	Funeral Hordtown, M	ome, P.A. D 20650-0279
г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the cone cause on each line.	leath. Do not ent	er the mode of dying,	, such as cardiac or	respiratory arres	t,	Approximate Interval Between
a	Physician		Immediate Cause (Final disease or condition	META	STATIC	- NONS	MALYCE	al Lun	G CA	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
		_	Sequentially list conditions,	b. Due to (or as a con	and the second					
	led sit	nine	ii any, leading to inimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence on,					
•	xecur and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					
68760,	ificate be executed g physician and as the burial-transit	Sai		d						
89	ificate g phy as the	edicai								
Box		by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnancy			23d. Date of deli	
0.	es that the death cer igned by the attendir be detached for use	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			Month	Day Year
₽.	hat the od by detac	Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderiving cause giver	n in Part I	23e Did toha	cco use contribute to	the cause of death?
Records,	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use					Traditying datase given		il .		obably 4 []Unknown
ecc	e law r has be 3e 2 sh	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	10 -	Son						performe	d? death?	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
	Physi this c	유	1 Yes 2 No		2 ER/Outpatier		4 Nutsing Hom		ce 6 ☐Other (Spec	cify)
2	ng f	lon	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Work?	? _	3d. Describe how	injury occurred	
Division of	death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		At home form ou		es 2 No	of Logation (Cam	at and Mumber of D.	and Dougla March as
<u>≥</u>	or in la	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	еві, тасіогу, опісе	20	City or Town,	et and Number or Ru State)	rai Houte Number,
	To the Hospital or Attant within 24 hours after deatl To the Funars! Director: completely filled in by the	Medical (29a. Certifier (Check only one) 29a. Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death nination and/or in	h occurred at the time vestigation, in my opi	e, date and place, ar inion, death occurred	nd due to the cau d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To th Vithin To th	Me	29b. Signature and title of certifier			29c. License	number	290	l. Date signed (Month	n, Day, Year)
			1 (osuran	/		050	686		1/20 /	3 S
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,					
			trumptop s.	CHHABRA	25500	Point	100K Dr.	+ Road	, MD 20	1620
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S		4				
	Registi	ar	AUII P	- Jakony Co	15	and s				

		Please	rype or Prin				-	_	•
		For State	State of Ma	-	partment of H		Mental Hygi	ene	01000
		Registrar		C	ertificate of	Death		g. N6 U U U	01333
Physi	ician	1. Decedent's Name (First, Middle, La		1	Bright		2. Date of Death January		3. Time of Death 5 11:30 P _M
/Med	dical	DOLOCHY	М.						
Exan	niner					r Location of Dear	tu	4c. County of De	
		12224 Dr. Edele 5. Social Security Number 6.		e (In yrs. last birthda	LaPla		5. 8 Date of Birth	CHALLE	
Funera Directo		213-84-9668	1□M 2\\ F	41 Yrs	Months Days	Hours Min.		1963 Ma	irthplece (State or Foreign Country) ryland
pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Aaryli I eho	à		es	LaPlat					¥ Yes 2 No
the A	Por	10e, Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
IOTE, INSTYISTIC ZIZIS-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-f ehow or other traumatic event, the Medical Examiner must be notified at	Funeral Director	12224 Dr. Edel	en Road		2064	6		USA	
death ms 2	Pers	11. Marital Status	12. Was Decedent I	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S	Specify Yes or No-	14. Race - An	merican Indian,
or ite	Ē	1 ☐ Never Married 2 ☑ Married	Armed Forces?	No			to Hican, etc.)	Black, Wh	
hours at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specity:		Specify: E	Black
72 h	at a	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. De	cedent's Usual Occup ive kind of work done e. DO NOT use retire	ation during most of wo	orking 1	6b. Kind of Busines	s/Industry
right of the last	Completed	Elementary/Secondary (0-12)	College (1-4or 5		e. DO NOT use retire omemaker	d)		Domest	ic
tygie her t	Ö		el .		Omemaker	10 Mathada Na	me (First, Middle, M.	oides Cumana)	
Viding build be file Mental Hy arked oth	8						III (FIISI, MIGGIÐ, MI	Plater	
nould Mei mark	P	George 19a. Informant's Name/Relationship		tes	ilian Addunas (Ctrast	Helen	west Double Attumbas		Zie Codel e e e
Man d 2 sl th an 7 is r		Don Bright/Hus			24 Dr. E				, Zip Code 20646
1 and 1 and Healther	1	20a. Method of Disposition			position (Name of crematory or other place		The same of the sa	Oc. Location - City of	
nt of re if it		1 ☐ Burial 2 X Cremation 3		Metrop		^(θ) 1/1		•	a,Virginia
Daillinore Dermit. Pages 1: Department of He mportant: If iten	ش	*4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	**	местор	22. Name and Addre		3,03		, , , , ,
permit. Pages 1 and 2 Department of Health a Important: If item 27 is	Succession	Dogam Ou		MO 1323	Adams Fu	neral E	Home P.A	. Aquas	co,Maryland
100		23a. Part1. Enter the disease, or con	nplications that caused	the death. Do not	enter the mode of dyir	ng, such as cardia	c or respiratory arres	it,	Approximate
Dhuaisia		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.		1150			Interval Between Onset and Death
Physicia: /Medica		disease or condition resulting in death)	a. Due to (or as	a consequence of):	(A) P	CEIR			
Examine	er		200 10 (01 00	2 00/100q00/100 0//.					
R.	i d	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
uted	Examiner	Cause (Disease or injury that initiated events	C						
ou, be executed ician and burial-transit			Due to (or as	a consequence of):					
COIDS, F.O. DOX DO/OU, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.	Cai		d						
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IC CCAALC.						T-	
ath cer attendir for use	Vue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		3 Ectopic pregnancy	,		23d. Date of d	
dea dea ha att	Sich	in the past 12 months?	4☐Pregnant at 9☐ Unknown		5 Other (specify)			Month	Day Year
at the 1 by a stach	Phy	9 Unknown			A-18-00-00-00-00-00-00-00-00-00-00-00-00-00				
es th igned	3	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause giv	en in Part I.			to the cause of death?
law requires the second	Completed			 			1 L Yes	2 No 3 I	Probably 4 Unknown
law law las by 2 st	alac						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
The The page	lo C						performe	death?	es 2 No
VII.di icien: T certificat ector, p	Be	25. Was case referred to medical				26. Place of De	ath (Check only one)		
Physic This co	P	1 ☐ Yes 25 No	Hospital: 1 Inpatie	ont 2 ER/Outpat		4 🗆 Nursing F	lome 5 Rèsiden	ce 6 Other (Sp	ecify)
Ing P	on:	27. Manner of Death	28a. Date of Injui (Month, Da)	y Year) 28b. Time Injur	y Wor		28d. Describe how	injury occurred	
SIC tend leath tor: /	cat	2 Accident investigated	he -			Yes 2 □No			
lor Attending after death. Director: After in by the fune	Certification:	4 Homicide determined		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
pital purs a ours a eral (hypinian To the heat	of my knowledge, de	ath assumed at the first				
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2.	edical	29a. Certifier 12 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or	investigation, in my o	ne, date and place pinion, death occi	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	is stated. ie to the cause(s)
rothin rothin roth	2	29b. Signature and title of certifier	1 1		29c. Licens	e number	290	I. Date signed (Mor	nth, Day, Year)
- >- 0	İ	1 Koul	MM	alle	020	-35)	11710	5
		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	e, Print)	10	^ '	1	
BI		LO Ro	x 170	03 1	a Plate	5 1	7) 70	646	
	State	31. Date filed (Month, Day, Year)		ar's Signature	1 .				
Regis	strar	JAN 1 1 2	2005	w It	market				

		1- For State of Maryland / Department of Certificate of Maryland		ental Hygie	•
Physic		Decedent's Name (First, Middle, Last) PATRICIA BROWN		2. Date of Death Month Jan	Day Year 4 2005 4:50 P M
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Tow	m, or Location of Death		4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs. Bys Hours Min.	8. Date of Birth (Month, Day, Y	Montgomery 9. Birthplace (State or Foreign Country) 1951 New York
e Maryland :a-f show	ctor	10a. State 10b. County 10c. City, Town or Location Md Montgomery Burtonsv.	ille		10d. Inside City Limits 1 □XYes 2 □ No
with the	i Director	#3 Crosswood Court, 20	de 866	10g	. Citizen of What Country?
DESILITION EY, INTERTY STATES A SECURIOR PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY IN THE MATCH PROPERTY OF HEMBER AND MANUAL HYGIENG. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Eventral must be notified at any price.	by Funerai		of Hispanic Origin? (Spec Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Bfack, White, etc.
vithin 72 hours aft no.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ccupation one during most of workin tired)	ng	Black b. Kind of Business/Industry
d be filed with the f	se Co	12th Grade Clerk Clerk Stather's Name (First, Middle, Last)	18. Mother's Name		U.S. Postal Serv.
ryiar	To B	Preman Brown	Alice	Jenki	
, Widl and 2 st valth and valth and valth and er treun					City or Town, State, Zip Code) Ville, MD 20866
ages 1 and of the control of the con)	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) *4 □ Donation 5 □ Other (Specify) Fair Lawn Ceme			c. Location - City or Town, State
Dallimor permit. Pages Department of important: If it any Injury or o		27. Signature of Euperal Service/acenses 22. Name and Ad	ddress of Facility SNC	WDEN FU	JNERAL HOME, F.A.
Physician /Medical Examiner		23a. Part 1. Entry he disease, or implications that caused the death. Do not enter the mode of shock, or hart failure. List only one cause on each line. Immediate Ca se (Final disease or condition resulting in death) a. Hurtington's Disease Due to (or as a consequence of):		respiratory arrest	Approximate Interval Between Onset and Death
oertificate be executed rding physicien and use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
law requires that the as been signed by the 2 should be detached.	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Progressive Dementia	given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
The lay ate has page 2	Completed			24a. Was an autopsy performed	
_ > ~ 0	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospital: 1 ☐ Inpatient 2 → Ft/Outpatient 3 ☐ DOA	26. Place of Death Other: 4 ☐ Nursing Hom		e 6 ⊡Other (Specify)
To the Hospitel or Attending Phyelclen: within 24 hours after death. To the Funeral Director: After this cartific completely filled in by the funeral director.	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 Opinists 6 Could get be	njury at 28 Work? 1 □ Yes 2 □ No	8d. Describe how	injury occurred
DIVI	O	4 Homicide determined 288. Place of Injury - At nome, farm, street, factory, offi building, etc. (Specify)		City or Town, S	
he Hosp n 24 hoi he Fune pletely fi	edicai	29a. Certifier (Check only one) 1 XCertifying Physician: To the best of my knowledge, death occurred at the Check only one) 1 Medicel Exeminer: On the basis of examination and/or investigation, in mand manner stated.	e time, date and place, ar ny opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within	Me		ense number D52261	29d.	Date signed (Month, Day, Year) Jan. 4, 2005
		30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Alan R. Segal, M.D. 34/15 Greencast	le Blvd, S	Silver S	Spring, MD 20910
St Regist	ate trar	31. Date filed (Month, Day, Year) JAN 1 1 2005 32. Registrar's Signature			

		1	For State Registrar	State o	f Maryland	d / Depa		of H	ealth a		-		e 200	5 0191
	Physicia /Medic	an	1. Decedent's Name (First, Midd	die, Last) Benton							2. Date of De Month Janu	eath D	² 4 200	3. Time of Death 12:18 A M
	Examin	er	4a. Fecility Name (If not institution UNIVEYS 1 My OF 5. Social Security Number			Cenkc	It Under 1	Ba l	lt Under 2	0 √e ∕ 24 Hrs.	8. Date of Bi	inth		eeth nove City Birthplece (State or Foreign Country)
	Director		578-26-1374 Usual Residence of Decedent 10a. State 10b. Count	1 □ M 2 🖾 F	85	Yrs.		Days	Hours	Min.	(Month, D Aug. 1	.6 ,	1919 No	orth Carolina
	the Marylan 28a-f ahow notified at	rector	D.C.		-		. D. (10g. C	Citizen of What	tXOXYes 2 □ No
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic avant, the Medical Examinar must be notified at	Completed by Funeral Director	4117 Beck Stre 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Dece	21 No ve				spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ocify Yes or N Rican, etc.)			mencan Indian, hite, etc. Black
nd 21215-0036	be filed within 72 hc tal Hygiene. d other then "natur avent, the Med cal	Be Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12		1-4or 5+)	(Give	dent's Usual kind of work DO NOT use ipervi	done d retired)	fu <i>ri</i> ng most) 18. Mothe	r's Name	(First, Middle	Fe		Sovernment
Maryland	nd 2 should be i alth and Mental i 27 is marked o	To E	Frank Jacobs 19a. Informant's Name/Relation Clementine B.	nship (Type, Print)	ighter				ın <i>d Numb</i> e	r or Rura			or Town, State	e, Zip Code) 20772
Baltimore,	Pa Lry		20a. Method of Disposition 1	(Specify)	State	t Line	osition (Name matory or oth coln C	eme	tery	1/8/0		Bre	entwood	or Town, State , Maryland
Bal	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service 23a. Part 1. Enter the disease,	Scrop or complications that	YV/V35	5.	538 Ma	r1b	oro P	ike/	uneral Forest	vil:	nes Le, MD	20747 Approximate
68760,	Physician and // / / / / / / / / / / / / / / / / /	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a	Sepsi (or as a consequ (or as a consequ (or as a consequ	ence of):								Intervat Between Onset and Death
P.O. Box 6	9 0 D	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	tcome of pregnar birth 2 ☐ Fetal nant at time of de nown	death 3	⊒Ectopic pre ⊒ Other (spe						23d. Date of Month	delivery Day Year
	requires een sign	eted by Pl	Part II. Dther significant condi	itions contributing to c	leath but not resu	alting in the u	inderlying ca	iuse give	en in Part I.		1 🗆] Yes	2□No 3□	
ital Rec	The larate has	Be Comple	25. Was case referred to medic examiner?	cal					26. Place	of Death	24a. Wa auto per 1 Yes	opsy formed 2 X	death	e autopsy findings available to completion of cause of 1? res 2 No
Division of Vital Records,	Attending Physical death.	Certification: To I	1	ding 28a. Date (Mor stigation and not be 28e. Place	of Injury oth, Day Year) e of Injury - At ho ling, etc. (Specify	ER/Outpatier 28b. Time of Injury me, farm, st	of 28	3c. Injury Work	4 ∐ Nu ⁄ at	No	28d. Describe	how in	and Number of	Specify) r Rural Route Number.
_	To the Hospital or, within 24 hours after To the Funeral Dire completely filled in b	Medical Co	(Check only 2 Medica		e best of my know pasis of examinat nner stated.	wledge, deal	nvestigation.	in my or	oinion, dea	d place, a	and due to the	, date a	ind place, and	due to the cause(s)
R	To To Son	2	29b. Signature and tittle of certification of the signature of the signatu	ballis	MD se of death (Item	23a) (Type	A	u4 1			15886	3 5	anuar	1 4 2005
	St Regist	ate rar	31. Date filed (Month, Day, Yea	2005 L	S. GVC Registrar's Signal	ture	511E		bull	111110	, IV	\(\(\frac{1}{2}\)	juliu	LILUI.

DHMH 17 Rev 1/2001

ORIGINAL

Amend item 11 per inf g840 2-3-05 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 2 per doctor 8840 2-3-05 vt
State of Maryland Department of Health and Mental Hygiene 1 1 5

1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Lay 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MELVIN BARON JAN. 2005 0705 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**★**M 2□ F 096-05-1589 MARCH 20, 1919 Director 85 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral, or items 23a or 28a-f show Engriser must be notified at 10d. Inside City Limits Director MD MONTGOMERY XXYes 2□No ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Prettyman Drive #4102 20850 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23i Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by Specify: → Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Buyer (Furniture) Furniture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Julia Crown Louis Baron 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Prettyman Drive #4102 Rockville, MD 20850 Anne K. Baron - Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
King David 20a. Method of Disposition 20c. Location - City or Town, State permil. Pages:
Department of H
Important; If ite
any injury or ot ₩ urial 2 Cremation 3 Removal from State King Dav Mem. 4 ☐ Donation 5 ☐ Other (Specify) 1-6-2005 Falls Church, VA Gardens 22. Name and Address of Facility National Funeral Home 1. Signature of Carana Security 7482 Lee Hwy Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) Cardiomopathy Unknown /Medical Due to (or as a consequence of) Examiner Aortic Stenosis Unknown Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last sician ar burial-t Due to (or as a consequence of) Box 68760 Physiclan/Medical nding physi use as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed Acute Renal Failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No autopsy performed? 1□ Yes ধ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🙀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 X Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hou. the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58681 January 4, 2005 30. Nary and sees of person who completed cause of death (Item 23a) (Type, Print) Jud∉ Alexander, MD SHADY Grove Adventist Hospital 31. Dale filed (Month, Day, Year) State JAN 1 0 2005 Registrar

			1 - For State Registrar	State of M	aryland	-	artment of F		ınd Me		ene 9. N2 ()	05	019	43
	Dhyciai	an	1. Decedent's Name (First, Middle,	Last)					2	. Date of Death Month	Day	Vass	3. Time of	Death
	Physici /Medi		Timothy	Willi		Bu	ırdeaux			January		Year 2005	4:15	a ^M
	Examir	ier	4a. Facility Name (If not institution, g	give street and number,	}		4b. City, Town, or	Location of	f Death		4c. Coun	ty of Death		
			7930 Mt. Harmony				Owings					alvert	:	
п	Funeral			. Sex 7. Ag 1⊠M 2□F		a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Day, Jan 27,	Year)	9. Birth	place (State of	r Foreign
	Director		214-72-2152 Usual Residence of Decedent	A	47	115.				Jan 27,	1957	Mar	yland	
	show		10a. State 10b. County		10c. City	, Town or Lo	ecation						10d. Inside Cit	v Limits
	Mary First	ţō	MD Calv	ert			Owings						1 ☐ Yes	-
	r 28a	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen o	f What Coul	ntry?	
	ours after death with the Maryla ral', or itams 23a or 28a-f shov Examiner must be inclifted at	a D	7930 Mt. Harmony	Lane			20	0736			US	SA		
	deat mms	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13.	Was Decedent of H If Yes, specify Cuba		in? (Specif	fy Yes or No-	14. R	ace - Americ		
9	or its	F	1 ☐ Never Married 2X Married				1 □Yes 2 X No	sn, mexican, Specify:	, Pueno Rio	can, etc.)		ack, White,	etc.	
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d 2	Hygid Hygid Sthar ant, th	e Co	17. Father's Name (First, Middle, La	 		PET A	TCE MITTE		r's Name //	First, Middle, M			dealer	
an	ould ba Mantal arkad o	00	William C		Dur	3001111	TTT			_	aluen Sum			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours if Health and Manfal Hygleine. item 27 is marked other then "natural", other traumetic event, If a Mudical Even	2	19a. Informant's Name/Relationship	(Type, Print)	DUL	deaux,	III	Shir		Ann	City or Tow	Care		
	ith ar		Dana Burdeaux,	spouse			Mt. Harn							
ē,	s 1 and 2 f Health itam 27 othar tra		20a. Method of Disposition		1	ace of Dispo	sition (Name of		Date			20736 City or To		
E G	Pages nent of int: if it iry or o		1 🔀 Burial 2 □ Cremation 3 3 4 □ Donation 5 □ Other (Spe				natory or other place cial Garde		01-08					
Baltimore,	nit. artm orta inju		21. Signature of Funeral Service Lig				. Name and Addres			2005	our it.	LICY I'M		
ä	Dep Per Suppose		William	R. Gro-	2	I	Rausch Fu	neral	Home	. P.A	Ow	ings,	MD 20	736
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cause	d the death							211907	Approximate)
	Fırysician		Immediate Cause (Final disease or condition			e Can	Cer						Interval Betw Onset and D	
	/Medical		resulting in death)	Due to (or as									6 hor	lins
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of it jury	Due to (or as	a consequ	ence of):							*	
	ecute and trans	Examiner	that initiated events resulting in death) Last	c										
8760,	ate be executed thysician and the burial-transit			Due to (or as	a consequ	ence or):								
687	ate:	dlcal		d										
	death certific e attending p id for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv					004.0			
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)					ate of delive lonth		ear
0	t the de by the tached	hysi	9 Unknown	9□ Unknown										
s, P	es that ignad t	by P	Part II. Other significant conditions	contributing to death b	out not resu	lting in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use co	ntribute to th	ne cause of de	ath?
ğ	law requires that the as been signad by th 2 should be detache]]	1 🗌 Yes	2 No	3 🗌 Prob	abiy 4 ∐Ur	nknown
Vital Record	awre is be	ompleted								24a. Was an	24b	. Were auto	psy findings a	vailable
Ä	o c o	E O								autopsy performe 1 Yes 22	d? S No	death?	npletion of ca 2□ No	use of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only one)		10163	2010	
of V	dis di	2	1 ☐ Yes 2 No	Hospital: 1 🔲 Inpati	ent 2 🗆 E	ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nur:	sing Home	5 🗷 Residen	ce 6 □Ot	her (Specify	1)	
		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injury Work	at ?	280	d. Describe how	injury occu	rred		
<u>s</u>	Attanding ir death. actor: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	he				Yes 2□N						
Division	D Sign	ertification;	4 Homicide determine	ad 286. Place of in	ury - At hor c. (Specify)	me, farm, str	eet, factory, office		28f.	. Location (Stre City or Town,	et and Num State)	ber or Rura	l Route Numb	er,
	spite	O	29a. Certifier 154 Certifying	Physician: To the heet	of my know	uladaa daash								
	tha Hospital hin 24 hours a tha Funaral I npletely filled	edical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	it examinati	on and/or in	estigation, in my op	ie, date and sinion, death	place, and n occurred	at the time, date	se(s) and m e and place	anner as st , and due to	ated. the cause(s)	
	To tha Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier	0			29c. License	number		290	I. Date sign	ed (Month, I	Day, Year)	
)			1 Wan	Banka		ins	D3	856	3	g	anus	06,2	005	
	6		30. Name and address of person wh	o completed cause of o	leath (Item	23а) (Туре,	Print)				-,	0-1-		
	10		Wayne Bie	o completed cause of constant of the constant	Mb	134 01	nens will	6 Ra	094,1	West (ZWY	MO	207	78
	Sta		31. Date filed (Month, Day, Year)	32. Registr	s Signati	ure each	1 00							
	Registr	ar	JAN	1 4 2007	ETELAS.	15.	BOSALL!							

					artment of Health and M	•	•	
			State Registrar		rtificate of Death	Reg	No. UU5	01944
П	Physici	_	1. Decedent's Name (First, Middle, Last) Thomas Earnest	Barber, Sr.		2. Date of Death January	6, 2005 ar	3. Time of Death 12:25 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death		4c. County of Deeth	<u> </u>
			Gladys Spellman Nursing		Cheverly		Prince G	
	Funeral Director		5. Social Security Number 233–66–3848 6. Sex 125 M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Feb • 20	^{'ear)} 9. Birthpl Coun 1943 West	ace (State or Foreign try) Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10	0d. Inside City Limits
	Ba-f ah	ctor	MD Calvert	Dunkirk				1 ☐ Yes 2√2 No
	with th	Funeral Director	10e. Street and Number 2185 Skyvilla Drive		10f. Zip Code 20754	109	p. Citizen of What Coun USA	try?
	death	nera		edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	an Indian,
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itema 23s or 28s-f ahow other traumatic evant, the Madical Evament must be notified at	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 2 Never Married 2 Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 3 Never Married 2 Never Married 3	2 No	1 ☐ Yes 2 X No Specify:	Hican, etc.)	Black, White, o	ite
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212	d within	ошь	Elementary/Secondary (0-12) College (I-4or 5+)	struction		Self Employ	ved
	be filed tal Hygid d other event, t	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	uiden Sumame)	
Maryland	2 should be filed and Mental Hygi Is markad other aumatic evant, I	ç	Stonewall 19a. Informant's Name/Relationship (Type, Print)	Barber	Coro			tis_
Ma	and 2 si eaith an n 27 ls i		Barbara Barber (wife)		Skyvilla Drive Du		D 20754	Code)
ore,	permit. Pages 1 and: Department of Health Important: If Itam 27 any injury or other tr once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo		-	c. Location · City or To	wn, State
Baltimore,	permit. Pages Department of I Important: If Its any Injury or o once.		* 4 ☐ Donation 5 ☐ Other (Specify)	Maryland			heltenham,	
Bal	permit. Departr Importu any inj		21. Signature of Funeral Service Licensee		2. Name and Address of FacilityLee 25 Southern Mary		Home Calver . Owings,	
760,	Physician /Medical Examiner be privip-transit up to privip-transit up t	cal Examiner	Sequentially list conditions, Due to cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of): (or as a consequence of):	rota Cardiova	uscalan	Orderse	Onset and Death
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
S, D	res that igned b	by Pł	Part II. Other significant conditions contributing to d	eath but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to th	
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Records,	he law e has t age 2 s	duc	renal Thilvre	1.10-1-		24a. Was an autopsy performe	prior to con death?	osy findings available npletion of cause of
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of Vital	Physician: this certific ral director,	2		Inpatient 2 ER/Outpatier			ce 6 ☐Other (Specify)
O	ng fter	tion	27. Manner of Death 1 Natural 5 Pending (Mon 2 Accident investigation	of Injury th, Day Year) 28b. Time o Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred	
Division	I or Attendi after death. Director: A J in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, string, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	(Check only 2 Medical Examiner: On the b	best of my knowledge, deatl asis of examination and/or in ner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as sta e and place, and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	7	29c. License number	290	I. Date signed (Month, L	Day, Year)
			1 Shullenl	Worla	7 170182	2 1	ANU ARY	1 2005
	5+1		3. Name and address of person who completed cau	se of death (Item) (Type,	Print)	10 HX.	THE MED ?	18/0
ì	St	ate		Registra's Signature	New y	14740	2	~ ' ' '
	Regist	rar	JAN 1 1 2005 I	Bleever &	Societies			

		•	1 = For State Registrar	State of Maryla	nd / Dep		lealth and	Mental Hyg	piene ea. No. 200	
	Physicia		Decedent's Name (First, Middle, Las	vis Brook				2. Date of Dea Month January	th Day Yee	
	/Medic Examin	_	4a. Facility Name (If not institution, give Lorien Nursing &	street and number)	'n	4b. City, Town, o	r Location of Dea		4c. County of De	eeth
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 10. Social Security Numb	9x 7. Age (In yrs	s. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. E	Birthplace (State or Foreign Country) IEW York
	the Maryland 28a-f ehow	Director	10a. State 10b. County MD Howard 10e. Street and Number		olumbia				Og. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23e or 28e-f ehow imatic event, the Moulcal Exerties marker rollified at	by Funeral	8662 Hayshed Lane 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	2104		Specify Yes or No- rto Rican, etc.)	United S	tates
Maryland 21215-0036	d within 72 ho giene. or than "natur . the Moulcal	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup s kind of work done DO NOT use retired	during most of wi d)	orking	16b. Kind of Busines	ss/Industry
ryland	should be fited ind Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Edward Bachman 19a. Informant's Name/Relationship (1)	Syne Print)			18. Mother's Na Helen K			-
	Health and 2 shot Health and tem 27 is my other traum		Nancy Shields/Daug	ghter	8662 Place of Disp	Hayshed I	Lane Col	umbia, MI		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 ie marke any injury or other traumatic. <u>once.</u>		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	,) M	etro Ci 044 2	matory or other planted or matory 2. Name and Address	1-1	rry H. Wi	Catonsvil tzke's Fa	le, MD mily FH Inc.
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or companies to the shock, or heart failure. List only of the shock of heart failure. List only of the shock of heart failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause on each line.	neunt of):	ter the mode of dyir				Approximate interval Between Onset and Death
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Division of Vital Records,	ng Phy Iter this ineral d	Certification: To Be	examiner? 1 Yes 25 No 27. Manner of Death 15 Natural 2 Accident investigation 3 Suicide 6 Could not by	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	of 28c. Injur Wor M 1	er: 4 🔯 Nursing	28d. Describe ho	ence 6 ⊡Other (Scow injury occurred	
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined 29a. Certifier Check only 2 Medical Exam	building, etc. (Spec ysician: To the best of my kniner: On the basis of examin	cify)	th occurred at the tir	me, date and place	City or Tow	ause(s) and manner	as stated
}	To the h within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	and and of if	29c. Licens		2	9d. Date signed (Mo	nth, Day, Year)
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			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 1 9 4 6
İ	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year A A D Y Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	_c Funeral		Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
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	h the M r 28a-f	Irecto	Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	s 23a c	ralD	310 Hermitage Drive 21921 United States
ဖွ	after de or item	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene inflortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show mithortant: if Item 27 is marked other than "natural", or Items 23 or 28a-f show any injury or other traumatic event, the Maryland Examination or content of the modified at once.	ted by	3 ★Widowed 4 □ Divorced If Yes, Give Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 15c. Decedent's Usual Occupation 16b. Kind of Business/Industry 16c. Decedent's Usual Occupation 16c. Decedent's Usual Occupation 16c. Decedent's Usual Occupation 16c. Decedent's Usual Occupation 16c. Decedent 16c. Dec
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ל מ	e filed val Hygie other t	Be Co	12 Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
rylai	hould b d Menta marked matic e	To	John Murdock Florence Hoyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Boute Number City of Town, State Zin Code)
_	and 2 significant and 2 significant and 27 is a significant are traus		19a. Informant's Name/Relationship (Type, Print) Linda Beamer/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Hilltop Road, Elkton, Maryland 21921
Baltimore,	ages 1 nt of He t: if iten r or oth		20a. Method of Disposition 20b. Place of Disposition (Name of CTTPIN COMMENT) 20c. Location - City or Town, State 3 Semoval from State 20c. Location - City or Town, State
altin	permit, P Depertme Importani any inlury once.		^4 □ Donation 5 □ Other (Specify) Memorial Park 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1. Signature of Funeral Service Licensee 22. Name and Address of Facility
m E	83188	-	21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
	r nysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition. The disease or condition and the death of the death of the disease or condition is death. Approximate Interval Between Onset and Death Onset and Death of the disease or condition is death.
1	/Medical Examiner		resulting in death) Due to (or as a consequence of): COKONARY ARTERY DISEASE 5 years
Ļ	p iii	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)
7	sate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
8760,	the the	dlcal	d
Вох	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery
o.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown Other (specify)
JS, P	ires that signed b	by	Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	s been si	Completed	Severe Mitral Regulgitation. CLL 24a. Was an 24b. Were autopsy findings available
			autopsy prior to completion of cause of performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
Vital	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1
Division of	ding Ph	lon; T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?
Visio	To the Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of thijury - At home, farm, street, factory, office building, etc. (Specify) M 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω.	To the Hospital or within 24 hours after to the Funaral Diccompletely filled in		29a. Certifier Check cert 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	the Ho hin 24 h tha Fu npletely	Medical	one) and manner stated. one your medical examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
•	To To		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059223 January 18, 2005
	0		30. Name and address of person who completed cause of death (Item 23a) (Type Print)
	Sta	te	MELCHORE. MADARAWG, MD 138 Cathedral St. Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Falishar's Signature
	Registr	ar	JAN 2 6 2005 Seem & Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar AAco cmh

Certificate of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer Dorothy Elaine Cannon 9, January 2005 4:05 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Episcopal Life Care Facility Mitchellville Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 195-10 1058 Yrs. 90 Director 16,1914 ΝŸ Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic avent, the Medical Examiner must be notified at Completed by Funeral Director 1 X Yes 2 ☐ No Prince Georges Mitchellville 10e. Street and Number 10a. Citizen of What Country? Itams 23a 10450 Lottsford Road #1107 20716 e filad within 72 hours after death at Hygiene.
Other than "natural", or Itams 23. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h should be Deforest Ross Bliss Helena Marie Morrissey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is 1 14107 Westholme Court Bowie, MD Salley Hein/ Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Gate of Heaven Cemetery 1/15/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Linensee 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Fracture right humerus 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a confequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law raquires that the death certificate be executed the burial-transit Due to (or a la consequence of): resulting in death) Last Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 Atherosclerotic vascular disease 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2 No 1 Yes 2 **3** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 **N**o Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Q Ssi Steel Win 1 🗌 Yes Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\text{Homicide} 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

ASO Greenway (Ar or Greenbelt, MD 20770

person who completed cause of death (Item 23a) (Type, Print)

trar's Signature

mo

Schissler

		•	Please 1 - State Registrar	State of Maryl	and / Depa		ealth and M	lental Hyg	_	ble.	148
	Physici		1. Decedent's Name (First, Middle, L Lloyd Mich	· _	narles :	Sr.		2. Date of Dear Month January	h Day 5 200	Year	of Death
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death	J	4c. County		
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	Funeral			TEN OFF	vrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	_{Year)} 928	Birthplace (State Country)	
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	yland		10a. State 10b. County		City, Town or Lo	ocation				10d. Inside	City Limits
	a-f s	cto	MD Prince	George's	Lando	ver				1 🔀 Ye	s 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Country?	
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2-003p	hours after tural', or ite	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ♣ No	Specify:		Specify	Black	
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7	within than the Man	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired,)	9	0		
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, Ma	and 2 salth a n 27 is		Evelyn M. Charl	es	2716	Kilmer Dr	rive Land	over, Ma	ryland	20785	
ore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1∑ Buriai 2 ☐ Cremation 3		 b. Place of Dispo cemetery, crer 	osition (Name of matory or other place	9)	Date	20c. Location -	City or Town, State	
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g n	Depar Depar Impor Impor		21. Signature of Funeral Service Lic	erisee						eral Home	
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	Physician /Medical Examiner	9	Immediate Cause (Final disease or condition resulting in death)		pulm squence of):	many	. am	est:		Interval Bronset and	
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VITa	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				
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	(10)		30. Name and address of person wh					1			14100
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	/Media	al	Willie Joseph Clark, Sr		Januar		
	Examir		4a. Facility Name (If not institution, give street and number) Vashington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		4c. County of De	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birtl (Month, Day	h 9.F	Littholace (State or Foreign
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	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	pcation			10d. Inside City Limits
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	or 28	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of What	-
	s 23a	erai	5701 Justina Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13.	20706		United Sta	
10	fter de	Fune	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Black, W	nerican Indian, nite, etc.
033	ours a	d by	Year or Dates: 11/56	1 ☐ Yes 2 to No Specify:		Specify: I	Black
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Maryland	2 2 2 2			ng Address <i>(Street and Number or Rur</i> a) Justina Dr. Lant	nam, MD		, Zip Code)
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Vital	Physician: this certifice ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death		ne) lence 6 Other (Sp	
Jo C	ding Phy n. After this funeral c	 	27. Manner of Death 28a. Date of Injury 28b. Time of			ow injury occurred	эөслу)
slor	Attending ar death. ector: After by the fune	catic	2 Accident investigation	M 1 Yes 2 No			
Division	l or Attend effer death Director: I in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	reet, factory, office 2	8f. Location (S City or Tow	itreet and Number or a n, State)	Rural Route Number,
_	spital nours nerei		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, a	nd due to the c	cause(s) and manner	as stated.
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one) and manner stated.	vestigation, in my opinion, death occurre	d at the time, o	date and place, and d	ue to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier Aftend. Ph	29c. License number D. 1989-		29d. Date signed (Mo.	
)) /	111		30. Name and address of corresponded course of death //least 2011 7	D. 1787		1. 7.0	
4	7) 1Va		30. Name and address of person who completed cause of death (Item 23a) (Type, V. SINGH 7209A HANOVER	PKWY GRE	FORE	LTMD	20770

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 1 1 2005

		For Stata	State of	Marylan		artment of		and Me	ental Hyg	iene		
		Registrar 1. Decedent's Name (First, Middle,	(act)		Cel	tificate o	T Death		2. Date of Dea	eg. No	15	0.1950
Physi		Margaret Je	_					1.	Month January	Day	Year	4:15 pm
/Med Exam	dical	4a. Facility Name (If not institution,		nber)		4b. City, Town	, or Location of		January	4c. County of		4:13 pii
-Au		3505 Young Rd.				Mano	chester	_		Car	roll	
Funera	al	5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs.		If Under 1 Yea Months Day		24 Hrs. 8 Min.	B. Date of Birth (Month, Day	Year)	9. Birthpi	lace (State or Foreign
Directo	or	220-20-4306 Usual Residence of Decedent	TO W ZAL	76	Yrs.			Z	April 8	, 1928	New	Jersey
/land		10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation					10	0d. Inside City Limits
Mary a-f sh	ţ	Maryland Carro	511		Taney	town					1	1 ∑
th the or 284	Director	10e. Street and Number				10f. Zip Code	•		1	0g. Citizen of W	hat Coun	try?
eth w		111 Grand Di					1787			USA		
er de Items	Funeral	11. Marital Status	Armed For		.S. 13.	Was Decedent of f Yes, specify Cu	f Hispanic Orig uban, Mexican	gin? (Speci 1, Puerto Ri	ify Yes or No- ican, etc.)		- America , White, o	an Indian, etc.
urs aft	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1 Tes If Yes, Giv Year or Da	0		1⊡Yes 25© N	lo Specify:			Specify:	W	hite
IIIG X IX I 3-0030 be filed within 72 hours after deeth with the Maryland la! Hygiene. d other than "naturel; or Items 23a or 28a-f show event, the Madical Exarcter must be multipled at	ted	15. Decedent's	s Education		16a. Dece	dent's Usual Occ	upation	A and		16b. Kind of Bus		
Lithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work dor DO NOT use reti	ie during most ired)	t of working	9			
led w lygier her th		12	0		Home	maker	1 42 12 11		(=)	own h		
Tallylalla ∠I∠I 2 should be filed within and Mental Hygiene. is markad other than eumatic event, the Ma	Be	17. Father's Name (First, Middle, L. William M. ((First, Middle, 1 Thomp	Maiden Sumame)	
should and Men marka	7	19a. Informant's Name/Relationsh			19b Mailir	na Address (Stre				City or Town, S	State Zin	Code)
IOTC, INICITY GILLO ALK 13-0030 ges 1 and 2 should be filed within 72 hours after deeth with the Maryla t of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f shot or other treumatic event, the Medical Expirit entitles in will be an or or other treumatic event, the Medical Expirit entitles at		Mia B. Clark		25		rand Dr						Code)
es 1 and 2 of Health 1 ltem 27 in other trees.		20a. Method of Disposition	Daughte	20b. P	lace of Dispo	sition (Name of natory or other p		Da	neytown	20c. Location - C	1787 City or To	wn, State
mit. Pages partment of I portent: If It		1 ☐ Burial 2√☐ € remation 1 ☐ Donation 5 ☐ Other (Sp	3 □Removal from 5 ecify)	state		remation		1/10,	/05	Hampste	ad, 1	Maryland
permit. Pages Department of Importent: If I	OUCE.	21. Signature of Funeral Service L	ice0see		22	. Name and Add	tress of Facilit	y Pritt	ts Fune	ral Home) ۍ د	Chapel, PA
	ä	John K Ho	0		4	12 Wash:	ington	Rd. I	Westmin	ster, M	aryla	and 21157
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that ca only one cause on ea	aused the deat ach line.	h. Do not ent	er the mode of d	lying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)	-dhi	mi	01	strine	lyrel	aln	unay	diser	د د	154
/Medica Examine		rooding in doding	Due to (or as a conseq	uence of):							100
	e E	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):						17	-509
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1		l							/
cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
o / oU cate be e cate be e chysician the burit	dicai		d									
as ∰ d	Med	IF FEMALE:	220 16 400 044									
BOX Bath cer attendir for use	hysician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnar Other (specify)				23d. Date Mont		ry Day Year
the d	ysic	1 U Yes 2 No 9 Unknown	9□ Unkno		eath 3L	J Other (specify)						
The Cords, F.O. Do. The law requires that the death ste has been signed by the atter age 2 should be detached for u	by Pt	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did tol	pacco use contrit	oute to th	e cause of death?
w require been sig							·		1 🗆 📉	es 2□No 3	B 🗌 Proba	ably 4 □Unknown
tawre as bec	piet								24a. Was a		ere autop	osy findings available inpletion of cause of
	Completed								perform	ned? de	ath?	2 □ No
ien iien ctor	Be	25. Was case referred to medical examiner?	Manital				26. Place	of Death (Check only on	e)	The state of the	016
Ol VII.a Physicien: this certific ral director,	J.	1 Yes 2 No			ER/Outpatien	3 DOA						Residence
ding h. After fune	tion	1 Matural 5 Pending 2 Accident investig		of Injury h, Day Year)	Injury	W	luiyat York? □Yes 2□1		id. Describe no	ow injury occurre	Q.	
INISION or Attending after death. Director: After	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, offic			Sf. Location (St	reet and Number	r or Rural	Route Number,
s after by Direction	Certification:	4 Homicide	buildir	ng, etc. (Specif	y)				City or Town	7, State)		
lospii hour unere		29a. Certifier 1 Certifying	Physician: To the xeminer: On the ba	best of my kno	wiedge, death	n occurred at the	time, date and	d place, an	nd due to the ca	ause(s) and man	ner as sta	ated.
UNISION ON VERTICAL TO THE HOSPITE OF Attending Physic within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral dire	Medical	oney	and manr	ner stated.	and and or in			ui occurreo				
T VIII	-	29b. Signature and title of certifier	2- //	. /			nse number			9d. Date signed	(Month, L	Day, Year)
ي		30. Name and address of person v	MILLE	A	- 00-) (T	1) 2	- Y 4	13		1/10	120	0
W&		30. Name and address of person v	Il Al Stran	Lo DK	Pank	Print) Poan	1 Wes	the	adon	mi	21	157
9	State	31. Date filed (Month, Day, Year)	32. R	gistrar's Signa			00.20	1:///	1		/	
100		JAN 1 (2005	10.0	W	C N .						

Discont		1 - For State Registrar 1. Decedent's Name (First, Middle,	•	Ce	rtificate of	<i>Death</i>	2. Date of D		5 Q. Time-of Beath
Physic Medi/		Ramona Pauline					Janu	ary ^{Day} 06	2005 4:50 pm
Exami	ner	4a. Facility Name (If not institution, Westminster Nur				r Location of Death nster	1	4c. County	of Death
uneral		5. Social Security Number 216–24–0959	5. Sex 7. 1 ☐ M 2 ☐ ¥F	Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth (ay, Year)	Birthplace (State or Foreign Country)
irector		Usual Residence of Decedent		70 115.			July	23 1928	MD
r show	ō	10a. State 10b. County C	arroll	10c. City, Town or L.	estminste	r			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
3e or 28a- st be notif	al Director	10e. Street and Number 2720 Bird Vie	ew Road		10f. Zip Code	157		10g. Citizen of V	
marked other than "natural", or Items 23e or 28e-f show matic avant, Ita Me Jisal Exan and must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	If Yes, Give	s? ₹No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (SI an, Mexican, Puerto Specify:	Decify Yes or N Dican, etc.)		ce - American Indian, ck, White, etc.
SalE	ted b	15. Decedent's	Year or Date Education	16a. Dece	dent's Usual Occup	ation			usiness/Industry
Ned Ned	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	or 5+) life.	kind of work done of DO NOT use retired	d) _			
c avant, 🏗	o Be Co	17. Father's Name (First, Middle, La Osborne R. Ride	•		Switchboa	18. Mother's Nam		e, Maiden Suman	lephone Co
othar traumatic	F	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Numi	ber, City or Town,	State, Zip Code)
ar trau		Ann E. Roach/da	ughter		Bird Vie		Westmin	ster, MD	21157
		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	3 □Removal from Sta	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	(8)	/ 07 /05	20c. Location -	City or Town, State
any injury or		 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie 			Crematio				stead, MD
any injury or once.		1 Mould	Peals, en_		Pritts*ft 412 Washi				
		23a. Pan. Enter the Isease, or c shock, or heart failure. List or	complications that	1400			10.7		, 10 21101
dical		Immediate Cause (Final disease or condition resulting in death)	a. Due (or	menta as a consequence of):		ng, such as cardiac			Approximate Interval Between Onset and Death
iner	licai Examiner	Immediate Cause (Final disease or condition	a. Due to (or c. (2a)	mentoa	strah	ng, such as cardiac	or respiratory		Approximate Interval Between
or use as the burial-transit	edicai Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcor	menta as a consequence of): cwent as a consequence of): strointes as a consequence of): strointes as a consequence of):	strah	e bleedo	or respiratory	arrest,	Approximate Interval Between Onset and Death
be detached for use as the burial-transit	by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or b. Due to (or c	n line. menta as a consequence of): cwent as a consequence of): frointeg as a consequence of): ne of pregnancy 2 Fetal death at time of death 5	Strah tinal Ectopic pregnancy Other (specify)	e bleedo	or respiratory	arrest, 23d. Dat Mo	Approximate Interval Between Onset and Death Years Months Warths te of delivery
oage 2 should be detached for use as the burial-transit and	Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the first of the first o	a. Due to (or b. Due to (or c	n line. menta as a consequence of): cwent as a consequence of): frointeg as a consequence of): ne of pregnancy 2 Fetal death at time of death 5	Strah tinal Ectopic pregnancy Other (specify)	e bleedo	23e. Did	23d. Dat Mo tobacco use cont Yes 2 54No s an posy	Approximate Interval Between Onset and Death Years Months Marths te of delivery onth Day Year ribute to the cause of death?
bage 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Etc. I was a final cause. The cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	menta as a consequence of): cwent as a consequence of): frointeg as a consequence of): frointeg as a consequence of): per of pregnancy 2 Fetal death 3 at time of death 5 as a time of death 5 but not resulting in the unitary 5 as a consequence of 5 but not resulting in the unitary 5 but not resulting	Strab final Ectopic pregnancy Other (specify) Inderlying cause give	en in Part I. 26. Place of Dea	23e. Did 1 24a. Wa autor 1 Yes	23d. Dal Mo tobacco use cont Yes 2 Mo s an 24b. Voormed? 2 [Mo one)	Approximate Interval Between Onset and Death Years Months Months Marths te of delivery with Day Year ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
oage 2 should be detached for use as the burial-transit and a state of the	To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Last Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d. Due to (or d. Hospital: 1 Inp: 28a. Date of I. (Month, I	menta as a consequence of): cwent as a consequence of): frointeg as a consequence of): frointeg as a consequence of): ne of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the unattent 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 5 attent 2 ER/Outpati	Strak tinal Ectopic pregnancy Other (specify) Inderlying cause give	en in Part I. 26. Place of Dea er: 4 Sursing Hoyart	23e. Did 1 □ 24a. Wa auto per 1 □ Yes th (Check only onne 5 □ Res	23d. Dat Mo tobacco use cont lives 2 Mo s an posy ormed?	Approximate Interval Between Onset and Death Year S Man Hos Man Hos te of delivery Inth Day Year ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? I Yes 2 No er (Specify)
are ries been signed by the attending physician and bagge 2 should be detached for use as the burial-transit and bagge 2.	To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	a. Due to (or b. Due to (or c. Due to (or d. Due to (or d. Due to (or d. Due to (or li Live birth 4 Pregnant 9 Unknown s contributing to death Hospital: 1 Inp. 28a. Date of It (Month, Ittion at be 28e. Place of	menta as a consequence of): cwent as a consequence of): strointeg as a consequence of): strointeg as a consequence of): ne of pregnancy 2 Fetal death 3 at time of death 5 but not resulting in the understand	Strah for al Ectopic pregnancy Other (specify) Inderlying cause give at 3 DOA Other at 3 DOA Other at 3 DOA Other at 3 DOA Other at 3 DOA Other at 3 DOA Other at 3 DOA Other at 3 DOA Other at 3 DOA Other	en in Part I. 26. Place of Dea er: 4 Sursing Hoyat	23e. Did 1	23d. Dat Moontobacco use contobacco	Approximate Interval Between Onset and Death Year S Man Hos Man Hos te of delivery Inth Day Year ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? I Yes 2 No er (Specify)
ate has been signed by the attending physician and U.S. bage 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Last Clisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 yes 2 No 27. Manner of Death 1 Matural 5 Pending investiga 3 Suicide 6 Could not determined 29a. Certifier 1 Certifying	Due to (or b. Due to (or c. Due to (or d. Du	as a consequence of): CWENT as a consequence of): Strointes as a consequence of): Strointes as a consequence of): The sequence of of the sequence of of the sequence of of the sequence of of the sequence of of the sequence of of the sequence of of the sequence of	Ectopic pregnancy Other (specify) underlying cause give the 28c. Injun Work M 1 1 reet, factory, office	en in Part I. 26. Place of Dea er: 4 Sursing Hoyat k? Yes 2 \(\text{No} \)	23e. Did 1 1 24a. Wa autr 1 1 Yes th (Check only one 5 Res 28d. Describe	tobacco use cont Yes 2 No s an psy 2 No one) idence 6 Oth how injury occurr (Street and Numb own, State)	Approximate Interval Between Onset and Death Year Samuel Months M
After this certific funeral director,	To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d. Due to for 1 Live birth 4 Pregnant 9 Unknown 1s contributing to death 1 Inp. 28a. Date of li (Month, ittion at be 28e. Place of building. Physician: To the be xaminer: On the basis	as a consequence of): CWENT as a consequence of): Strointes as a consequence of): Strointes as a consequence of): The sequence of of the sequence of of the sequence of of the sequence of of the sequence of of the sequence of of the sequence of of the sequence of	Ectopic pregnancy Other (specify) Int 3 DOA Other M 28c. Injun Worl M 1 reet, factory, office th occurred at the tin evestigation, in my of	en in Part I. 26. Place of Dea er: 4 Sursing Hoyat k? Yes 2 No	23e. Did 1 1 24a. Wa autor 1 1 Yes th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco use cont Yes 2 No s an posy one) idence 6 Oth how injury occur (Street and Numb wm, State) e cause(s) and ma date and place, a	Approximate Interval Between Onset and Death Year Samuel Months M

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** IVA EDNA UTZ CLABAUGH JAN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12 BAUMGARDNER AVE. TANEYTOWN CARROLL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X F 77 Director 216-22-7527 9/5/1927 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28e-f ehow other traumatic event, the Madical Exprendent must be notified at 10d. Inside City Limits MD. CARROLL Director TANEYTOWN 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 BAUMGARDNER AVE. 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ont if item 27 is marked other than "naturel", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE WORKER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STANLEY STOUTER HELEN EYLER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET ROBINSON - DAUGHTER 7134 MacBeth Way, Sykesville, MD. 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite 1 X Burial 2 Cremation 3 Removal from State MEADOW BRANCH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 1/10/05 WESTMINSTER, MD. Signatare of Funera 22. Name and Address of Facility FLETCHER FUNERAL HOME MAIN ST., WESTMINSTER, 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforr certificate 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 1 ☐ Yes 2 No 1 🗌 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 5 Nesiderice 6 ☐ Other (Specify) this uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) Willow 295 Kus Stoner 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of N	Maryland /		artmen:				lental Hy	/gien		5	01953	
	Discount of	4	1. Decedent's Name (First, Middle, La	st)							2. Date of D	eath			3. Time of Death	_
	Physici /Medic		Henrietta Matild	a Combs							Januar	р 13		Year 005	5:20 P M	i
	Examin		4a. Facility Name (If not institution, give	e street and number	er)		4b. City,	Town, or	Location	of Death		40	. County	of Death		_
		•	St. Mary's Hospi						dtown				St.	Mary	¹s	
г	Funeral		5. Social Security Number 6. S	Sex 7 I□M 2 X F	Age (In yrs. last i	,,	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth ay, Year,)	9. Birthp	lace (State or Foreign	7
	Director		216-80-1196 Usual Residence of Decedent		95	Yrs.					Nov. 2	28, 1	909		y1and	
	and and		10a. State 10b. County		10c. City, To	wn or Lo	ocation								0d. Inside City Limits	_
	Mary she	ō	Maryland St. M		T	1	.								1 □Yes 2X No	
	28a	Director	10e. Street and Number	ary s	Leo	nard	town 10f. Zip	Code				10a Ci	tizen of W	hat Cour	ntry?	_
	3a o	O I	45270 Medley's	Neck Road	1		20	650							,	
	death ms 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13.			spanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)		S.A. 14. Race	- Amend	an Indian,	_
9	after or Ite		1 ☐ Never Married 2 ☐ Married	Armed Force 1 Yes 2		- 1	irves,spec 1⊡ Yes 2				Hican, etc.)	į		k, White,	etc.	
8	72 hours after death with the Maryland natural', or tems 23a or 28a-f show Jicel Eraturner must be trofffed at	d by	3X Widowed 4 □ Divorced	Year or Date	s:		10 105 4	A LI 000	Specify:				Specify:	Whi	te	
21215-0036	natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	(Give	dent's Usua kind of wor	k done d	turing mos	t of work	ing	16b. F	(ind of Bus	siness/In	dustry	
12	within ene. than *	du	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT us)							
	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "natural", or flems 23a or 28a-f show event, the Medical Exam as must be redified at		8 17. Father's Name (First, Middle, Last)		Hom	e Mak	er	10 Math	r'a Nam	e (First, Middle		wn H			_
ano	ontal l	Be c												9/		
2	2 should be and Mental is marked or raumatic ev	2	John Alexander G 19a. Informant's Name/Relationship (10	Dh Maili	aa Addraes	(Street)			lizabet			24-4- 7:-	0-4-)	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic										al Route Numb					
	of Health item 27 other tr		Patricia A. Knott 20a. Method of Disposition	_/_Granuc	20b. Place	of Dispo	osition (Nami matory or ot	urey ag of	SNE		nd. Leo Date		ocation - 0			-
Baltimore,	0 0		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif						4							
≣	# 문문구		21. Sign du uner de Lice		SE. I		ael's				7 - 05			-	ryland	-
B	Dermi Depa Impo any ir		Edward N. Brinsfi	eld, Jr.	Mooo52					DI.					ne, P.A. land 20650	`
		7	23a. Part1. Enter the disease, or com	plications that caus	sed the death. De	o not en	er the mode	of dying	g, such as	cardiac	or respiratory a	arrest,	wii, i	Mary.	Approximate	,
	Priysician		Immediate Cause (Final	one cause on eacr	1 line.					į.					Interval Between Goset and Death	
	/Medical		disease or condition resulting in death)	aDue to (or:	as a consequenc	e of):	77.7	11100	>11 - / •					-	MAYS	_
	Examiner			ATHERL	OCARDA as a consequence OSCUEN	011	CON	LD10	VAR	VU	ta 278	TAS	E		YEARS	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequenc											-
	cuted nd ransi	Exami	that initiated events	C												
ó,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	as a consequenc	e of):										
8760,		Physician/Medical	•	d												
9		Mec	IF FEMALE:													_
Вох	eath certif attending for use a:	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pre						23d. Date Mont		ry Day Year	
o.	the g	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant 9□Unknown	t at time of death	5 L	Other (spe	ecity)					1410111		ou, rou	
۵.	requires that the d leen signed by the hould be detached		Part II. Other significant conditions of	contributing to death	n but not resulting	in the u	nderiving ca	IUSA CIVA	n in Part I		23e Did	tobacco	use contrib	hute to th	e cause of death?	
ds,	uires tha signed d be del	d by	A 2HEIMERS	DENIE	NSTIA	, =		.uoo g.vo							ably 4 Unknown	
20.	w requir been si should	lete									-					
Vital Record	e fav has je 2	Completed									24a. Was		pr	ere autor for to cor eath?	osy findings available npletion of cause of	
<u></u>			05.116								1 ☐ Yes	2 1 M		Yes	2 X) No	_
ž		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Othe			n (Check only		377.5			
of	Phys r this oral di	\vdash	27. Manner of Death	28a. Date of Ir		Jutpatier . Time o		A	4 L Nu		me 5 Res 28d. Describe				7)	-
on	th. th. : After th	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	Day Year)	Injury	м	Bc. Injury Work	:? ′es 2 🗀 I		200. 20001120	now and	19 0000110	-		
Division	or Attending I after death. Director: After in by the funer	ertification;	3 Suicide 6 Could not b	e 28e. Place of	Injury · At home,	farm, str	eet, factory,			-	28f. Location	Street ar	nd Numbei	r or Rura	l Route Number,	-
ā	al or A s after I Dire	ert	4 Homicide	building,	etc. (Specify)						City or To	wn, State	9)			
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Salc	29a. Certifier XX Certifying Ph	ysician: To the be	st of my knowled	ge, deat	n occurred a	at the tim	e, date an	d place,	and due to the	cause(s	and man	ner as st	ated.	_
	n 24 he Fi	edical	(Check only one) 2 Medical Exar	niner: On the basis and manner	or examination a	and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time,	date and	d place, ar	nd due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					. ~	number			29d. Da	te signed	(Month, I	Day, Year)	_
			· Mul					DS	6091	6			18-	05		
			30. Name and address of person who		f death (Item 23a) (Type,	Print)	800	. 11	tai	YMOOI	> 1	MD	20)6 36	
	Sta	-	31. Date filed (Month, Day, Year)	2005 32. Re	strar's Signature		South.	A								
	Registr															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 5 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Rosemary Jeane Denis January 0401AM 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 □ F

71

Funeral Director

Physician

/Medical

212-42-0320

Usual Residence of Decedent

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Example Tribut be motified at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	10a. State 10b. County	10	c. City, Town	or Loca	tion						10d. Inside City Limits
to	Maryland K	Kent	Chest	ert	Own						1 ☐ Yes 2 ☐ No
rec	10e. Street and Number				10f. Zip Code				10a. Ci	itizen of What Co	untry?
0	24184 Langford Roa	nd				2162	20		-	USA	,
era		12. Was Decedent Eve	r in U.S.	13. Wa				cify Yes or No	-	14. Race - Ame	ncan Indian
F	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☐ X o			s Decedent of H es, specify Cuba	an, Mex	ican, Puerto P	Rican, etc.)		Black, White	e, etc.
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🖺	Yes 2 No	Spec	cify:			Specify: WII	ite
ed	15. Decedent's Edu	cation	16a. [Deceder	nt's Usual Occup	ation			16b k	(ind of Business/I	ndustry
plet	(Specify only highest grade	e completed)	(Give kit	nd of work done of NOT use retired	during r	most of workin	g			. Industry
Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	Но	mem	aker				Ωτ	wn Home	
O	17. Father's Name (First, Middle, Last)					18. M	other's Name	(First, Middle,			
To Be	John Robert Mil	.es				Jo	vce Em	ily Mo	rphy	J	
 	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b.	Mailing	Address (Street					or Town, State, Z	ip Code)
	Alma Denis D	aughter								n, MD 21	
	20a. Method of Disposition		20b. Place of I	Disposit	ion (Name of		_	ate		ocation - City or 1	
	1 Burial 2 Tremation 3 R				tory or other place	•		1 /0 /0 /			
	' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Chesape		Cremat			1/8/05	Ste	evensvil.	le, MD
	21. Signature of Fulleral Service Cicerist	11/11/1	5						_		
	220 Bott Ester the disease or combine	while	death Done							H. Ches	tertown, MD
	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or					g, sucn	as cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Horn	tic 1)	135	ection					1	4-5 days
	resulting in death)	Due to (or as a co	onsequence of):							, ,
	Sequentially list conditions.	0.									
inel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):							
am	that initiated events	o									
Ĕ	resulting in death) Last	Due to (or as a co	onsequence of):							
ca		d					 				
Completed by Physician/Medical Examiner	IF FEMALE:										
an/I	23b. Was decedent pregnant 2	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 □E	ctopic pregnancy					23d. Date of deliv	1
Sici	in the past 12 months? 1 ☐ Yes 2 XNo	4☐Pregnant at tim 9☐ Unknown			ther (specify)					Month	Day Year
hy	9 🗆 Unknown								-		
by f	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in t	he unde	orlying cause give	en in Pa	art I.	23e. Did to	bacco	use contribute to	the cause of death?
ed	<u> </u>							1 □ Y	es 2	□No 3⊠Pro	bably 4 Unknown
oiet								24a. Was		24b. Were aut	opsy findings available
E							·	autop perfor	med?	death?	ompletion of cause of
e C	25. Was case referred to medical					06 Pt	see of Dooth	1 X Yes		1 □ Yes	2 🕱 No
8	examiner?	lospital:	2 □ EP/Outr	ationt	3□ DOA Othe			(Check only or		C □ Oth (C	
To To	27. Manner of Death	28a. Date of Injury	28b. Tir		28c. Injury	rat		e ⊃∟ Hesid 8d. Describe h		6 Other (Speci	ry)
tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ea <i>r)</i> Inj	ury	28c. Injury Work	<br Yes 2			,-	,	
lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	At home, farm	n street				Rf Location (S	treet ar	nd Number or Rur	al Route Number
ertii	4 ☐ Homicide determined	building, etc. (S	Specify)	, 011001	, radiory, office			City or Tow	n, State)	ar rioute ramber,
S	29a. Certifier 1 🔀 Certifying Phys	sicien: To the best of m	v knowledge	death o	Scured at the tim	an data	and place as	ad due to the a		\ and mineral	12
Medical Certification:	(Check only 2 Medicel Examir	ner: On the basis of exa	amination and/	or inves	stigation, in my op	oinion, o	teath occurred	d at the time, o	ause(s)	d place, and due t	o the cause(s)
Me	29b. Signature and title of certifier				29c. License	numbe	Ðr	2	29d. Da	te signed (Month,	Dav. Year)
	1 Emon	MU Siva	rical Re	side.	nt AT 20						,,,
						276	1	1	. /	6105	
	30. Name and address of person who co	mpleted cause of death	(Item 23a) (T	ype, Pri	nt) (200	~ 11(0	SIJOW	MI	ad, m	IV

State Registrar

East University

31. Date filed (Month, Day, Year)

PKNY

32. Registar's Signature

			For State Registrar		State	of Marylar		artment <i>rtificate</i>			and M	ental Hy	giene Reg. No	CHID	019	155
	Physici	an	1. Decedent's Name (F									2. Date of De	-	y Year	3. Time of	
	/Media		THOMAS DA									JANUAR	_	, 2005 ^{ear}	21:55	M
	Examir	ner	4a. Facility Name (If no CHESTER R.		-			4b. City, T		Location of CERTO			4c.	County of Deat	h	
	Funeral Director		5. Social Security Num 136-26-803	36	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Months	Year Days	If Under a	Min.	8. Date of Bir (Month, Da JANUAR)	rth ay, Year) Y 26	9. Birtl Co	hplace (State ountry) DELAWA	•
	and and		Usual Residence of De 10a. State 10	Ob. County		10c. C	ity, Town or Lo	cation							10d. Inside C	ity Limits
	Mary Ind	to	MD	KE	NT		ROCK I	IALL								2 ∑ No
	h the	irec	10e. Street and Number	er				10f. Zip C	Code				10g. Cit	izen of What Co	untry?	
	23a c	alD	3948 EAST	ERN N	ECK ROAD				216	61			USA			
036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 show ta Modical Examirat must be notified as	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		Armed F	2.271.No Sive	1	Was Decede f Yes, specif 1 ☐ Yes 2			gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	D-	14. Race - Ame Black, White Specify: W		
5-0	72 hours "natural", olesi Exe	eted	(Specify	. Decedent	's Education t grade completed	n	16a. Dece	ient's Usual kind of work	Occupa	tion uring most	of workin	ia.	16b. K	ind of Business/l	Industry	
21215-0036	filed within Hygiene. other than "	Completed	Elementary/Seconda			(1-4or 5+)	life.	OO NOT use ATING	retired)	•		-	CON	NSTRUCTI	ON	
Maryland	ed ta b w	To Be C	17. Father's Name (Fir WILLIAM						(First, Middle		Sumame) EMMELL					
Man	and 2 should all and Men n 27 Is marke		19a. Informant's Name											or Town, State, Z		
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tra		20a. Method of Dispos 1 ☐ Burial 2 🛣 0	Cremation		n State	Place of Dispo cemetery, crer ESAPEAK	sition (Name natory or oth	of er place	,	Da	ate	20c. Lo	STEVEN	Town, State	MD
altin	permit. Page Department o Important: If any injury or once.		° 4 ☐ Donation 5 (OIL	22	. Name and	Address	of Facility	Y					
<u>m</u>	8 8 E 8 8		Kuk	4.5	thete-	Q_	1.	SO SPE.	ER R	UAD,	CHES	STERTOW	VN. M	TUNERAL MARYLAND	HOME, P. 21620	.A.
	Physician /Medical		23a. Part1. Enter the shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	allure. List o	a. Hu	eath line.	ins f	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,	12	Approximat Interval Bet Onset and I	e ween Death
8760,	cate be executed physician and physician transit the burial-transit	al Examiner	Sequentially list condition of any, leading to immer Cause (Disease or injustrat initiated events resulting in death) Las	ıry	b. <u>Se</u> Due N	o (or as a consec	quence of):								5 d	ay
9	certificate ding phys se as the	/Medical	IF FEMALE:		d	utcome of pregn	ancy		_	05						
.O. Box	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physiclan/M	23b. Was decedent pr in the past 12 mo 1 Yes 2 N 9 Unknown	nths?	1 Live	birth 2 Feta gnant at time of c	al death 3	Ectopic pred Other (spec						23d. Date of deli Month		Year
Records, P.	w requires that been signed be should be det	by	Part II. Other significa	nt conditio	ns contributing to	death but not res	sulting in the u	nderlying cau	ıse giver	n in Part I.		23e. Did t	_	use contribute to No 3 ☐ Pro	the cause of dobably 4 DL	
al Reco		Completed										24a. Was autor perfo 1 Yes		death?	topsy findings a completion of ca	available ause of
Vital	Prysician: Th this certificate ra director, pag	Be	25. Was case referred examiner?	to medical	Hospital: _	-						(Check only o				
o	Phys r this ra dii	on: To	1 Yes 2 No 27. Manner of Drati	5 Pending	28a. Da	Inpatient 2 Injury nth, Day Year)	ER/Outpatien 28b. Time of Injury		Other c. Injury Work?	4 🗀 1401	-	e 5 🗌 Resid 3d. Describe I		6 Other (Spec by occurred	ify)	
Division	o Attending iffer death. Di ector: Aftel in by the fune	Certification:	2 Accident	investig 6 □ Could n determi	ot be 28e. Place	ce of Injury - At h ding, etc. (Speci	ome, farm, str	eet, factory,		es 2□N		3f. Location (: City or Tox	Street an wn, State	d Number or Rui)	ral Route Num	ber,
	To the Hospital or Attant within 24 hours after death To the Funeral Dilector: completely filled in by the		29a. Certifier 1) (Check only 2)	Certifying	g Physician: To the	basis of examina	owledge, death	occurred at	the time	, date and	d place, ar	nd due to the	cause(s)	and manner as	stated.)
	ro the within 2 ro the complet	Medical	one) 29b. Signature and title		and ma	nner stated.			License		/			e signed (Month		-
	->-0		160	2	()_	· 7 —		7)/	64	8	3		/12/	105	/
			30. Name and address	of person	no completed cau	of death (Iter	m 23a) (Type,	/	Le	ste	- 1	ow,	1	MI	216.	20
	Sta Registi	_	31. Date filed (Month,	JAN 1	2 2005	Registrar's Sign	ature	Locale	8	-			,	al .		

ORIGINAL

			1 – For State Registrar	State of Ma		artment of F		nd Mental Hy	giene)5	019	57
	Dhii		1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	V	3. Time of D	Death
	Physici /Medio		Dustin Thomas D	ittes				Januar	y 06°, 20	005	05:22	ΑM
	Examin		4a. Fecility Name (If not institution, give North Arundel Hosp			4b. City, Town, o		Death Burnie	4c. County Anne		del	
	Funeral Director		217 23 7407	x 7. Ag XM 2□F	e (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		th 19, Year) 2,1986	9. Birthi Cour Mar	olace (State or ntry) y Land	Foreign
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City	Limits
	Mary f sh	to	MD Anne Ar	unde1	Edgewat	er					1 X Yes 2	
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?	
	23a o		510 Overhill Dri	ve		2103	6		USA			
	eme eme	Funeral	11. Marital Status	12. Was Decedent in Armed Forces?	Ever in U.S. 13.			in? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac		can Indian,	
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🟋	10	1 ☐ Yes 2 🕱 No	Specify:	r donto i nozin, did.,		k, White, "Whi:		
0	hour	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	l 16a Daca	dent's Usual Occup	ation					
15	nin 72 n "na Nedic	plet	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most	of working	16b. Kind of Bu	ısınəss/in	dustry	
212	filed within 72 hours after death with the Maryland Hyglene. that than "natural", or Iteme 23a or 28e-1 show that the Mudical Exart wermust be redified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5		Student			Educa	tion		
pu	_ 0 0	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle,				
yla		P	Martin Philip Di				Lauı					
Mar	C) " = G		19a. Informant's Name/Relationship (T) Martin P. Dittes/			ng Address <i>(Street</i> Overhill		or Rural Route Number			_	
e,	of Health itam 27 other tr		20a. Method of Disposition	- Tather	20b. Place of Dispo		DITA	Edgewate	20c. Location -	21036		
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H important: if ita any injury or ot		1 🎇 Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)		Lakemont	natory or other place	ce) 1	1/10/2005	Davids			
ıţ	artme ortan injur		21. Signature of Juneral Service Licens		Gardens	2. Name and Addres	i					
ñ	Depa Impo any i		+ KYSpt				0.0	Robert E. s koad bow	Evans Fi	unera 2071		
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Akad d	10.	er the mode of dyin	200	ardiac or respiratory at	rrest,		Approximate Interval Betwee Onset and De	
8760,	ficate be executed sphysician and stree burial-transit a	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):							
.O. Box 68	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of delive	ery Day Ye	ar
Records, P.	res that igned b be deta	by	Part II. Other significant conditions co	ntributing to death be	ut not resulting in the u	nderlying cause give	en in Part I.		obacco use contr	ibute to th	V.	
CO	> 0 %	olete						24a. Was	an 24b. V	Vere auto	psy findings av	aliable
	The ate h page	e Completed	25. Was case referred to medical					1A Yes	rmed?	rior to co leath?	mpletion of cau 2□ No	se of
Vital	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 XER/Outpatier	t 3 DOA Otho	or.	of Death (Check only o sing Home 5 - Resid		· (C'4		
of	g Physical (ser thi		27. Manner of Death	28a. Date of Injui (Month, Day		28c. Injury	/ at		ow injury occurr	ed		5
Division	Attanding r death. ector: After y the fune	Certification:	1 □Natural 5 □ Pending 2 Accident investigation	116105		AM 1□		· intel	Just	my	ven	4
Ν	or Attuetter de Directo	rtific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office	*	28f. Location (S City or Tox	Street and Numbern, State)		Route Numbe	1.
	urs ef urs ef urai D				poorling	ny		Pord, a	morel	· L	lour la	and I
	Hospital (24 hours er Funarai Distely filled i	edical	29a. Certifier 1☐ Certifying Phy (Check only one) (Check only one)	ner: On the basis of	examination and/or in	n occurred at the time vestigation, in my of	ne, date and pinion, death	place, and due to the on occurred at the time,	cause(s) and ma date and place, a	nner as st ind due to	ated. (the cause(s)	,
	To the Hospital or Attanding Physician: Within 24 hours efter death. To the Funaral Director Atter this certific completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and manner sta	nou.	29c. License	e number		29d. Date signed	(Month.	Day, Yearl	
	F S F Ö		The st	76-0		0.C.	M.E.		January			,
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type,	Print)						
			THEVOORE MICE		111 Pe	nn Street	, Bal	timore, Man	ryland 2	1201		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 0 20		ar's Signature	and .						

			For State Registrar	State of M	arylan		artment rtificate			d Mental H	ygien Reg. N	Z 11 11	5 01	958
			1. Decedent's Name (First, Middle, Last)						2. Date of D			3. Time of	Death
	Physici /Medi		Veda Gear	Da	vis					Janua	ry 5	, 2005	02:30) a ^M
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, To	wn, or L	ocation of D	eath	1	c. County of D		
			Calvert Memorial	Hospita.	1		Pri		Frede			Calver	ct	
	Funeral Director		5. Social Security Number 6. Se 528-22-0255 Usual Residence of Decedent	x 7. Ag]M 2∏7F	ge (In yrs. li 82	ast birthday) Yrs.	If Under 1 Months [Year Days	If Under 24 H Hours N	Hrs. 8. Date of B (Month, 2 Mar 2	irth Pa <i>y</i> , Year 1 , 1	922 O	Birthplace (State or Cou <i>ntry)</i> Klahoma	r Foreign
	land		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Cit	v Limits
	Mary	ō	MD Calvert	_			(II)		1 - F	1.			1 ▼ Yes	-
	tha 28a	Director	10e. Street and Number	-			10f. Zip C		eake E	eacn	10a C	itizen of What	Country?	
	3a o	O	8225 C Street					207	32			USA	,	
	daati ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. y	Was Deceden			(Specify Yes or Nuerto Rican, etc.)	0-		merican Indian,	
9	aftar or ita		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2√☐ If Yes, Give		1				ierto Rican, etc.)		Black, W	hite, etc.	
8	72 hours aftar daath with tha Maryland natural', or itams 23a or 28a-1 ahow disal Examinar must be notified at	1 by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			1⊡Yes 2∑	Q No	Specify:			Specify:	white	
21215-0036	72 hours after death with the Marylan Insturel", or items 23e or 28e-1 ehow dical Examiner must be rrollified at	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Deced	lent's Usual (Occupati	ion ring most of	working	16b. I	Kind of Busine	ss/Industry	
2	within ena. than *	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use	retired)		· ·				
2	ba filad within 72 ho ital Hygiena id othar than "natur evant, the Medical		17. Father's Name (First, Middle, Last)	1	1	Aeros	pace S	_					Governmen	ıt
Maryland	Mantal Parked of	Be		Con	_					Name (First, Middl		,	- 11	
Z	d 2 should be th and Manta 7 is marked traumatic ev	2	Larkin Claud 19a. Informant's Name/Relationship (T)	Gea:	<u>r</u>	10b Mailia	a Addraga /S	Stenat or	Marth		roli		Junell	
Za	12 s h ar 7 is		Eloise McCoy, nied							Rural Route Num				· O
ō,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Pl	lace of Disposemetery, crem				t 118, B	1		VA 2406 or Town, State	U
<u>o</u>	e o = 5		1 X Burial 2 ☐ Cremation 3 X F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State						01 00 05			or rown, oraco	
Baltimore,	parmit. Pag Dapartmant Important: I any injury o		21. Signature of Funeral Service Licens	90	WO		. Name and A			01-08-05	мца	III, FL		
ä	Day Imp		1 10 Olian F	2 Ju	_	R	ausch	Fine	eral H	ome, P.A	,	Dwings,	MD 2073	6
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death							wings,	Approximate	
V.	Physician		Immediate Cause (Final disease or condition	Acus	1	Panc	High	th					Onset and D	eath
T	/Medical		resulting in death)	Due to (or as			EUII			4			1/20	days
	Examiner		Sequentially list conditions	Acut	e M	esent	eric,	Art	terral	Isch	em	izi	1-20	deurs
	D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):							1-20 years	0
	and -trans	Examine	that initiated events resulting in death) Last	Due to (or as	mine		344	14A	heros	clerosts			years	;
8760,	cata ba axacuted bhysician and tha burial-transit	aE		Due to (01 as	a consequ	ence or).								
687	daath cartificata ba axacuted e attanding physician and id for usa as tha burial-transii	edicai		d										
Вох	h cartific anding p usa as	/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnan	ncy						23d. Date of c	lelivory	
ă	daath a attan d for u	cia	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregr Other (special					Month		ear
P.0	ras that tha da signad by the a ba datached t	Physician/M	9 Unknown	9□ Unknown										
	raquiras that tha aan signad by th nould ba datache	ру Р	Part II. Other significant conditions con		. T	A		Λ.		23e. Did	tobacco	use contribute	to the cause of de	ath?
of Vital Records,	w raquir baan si should I	ted	10	betructo	-	vmov		-		_ 1 🗆	Yes 2	MNo 3□	Probably 4 □Ur	nknown
ecc	law as b	pie	Advanced Pen	pheral	Vas	rula	Dis	eas	Q,	24a. Was		24b. Were	autopsy findings av	vailable
= H		Completed	Hypo tens Im	'	Jerd	emta					ormed?	death'	?	J36 OI
/ita	Physician: This certifical	Be	25. Was case referred to medical examiner?							eath (Check only	one)			
of	ys dis	0	1 165 2 2 140	lospital: 1 inpatie		R/Outpatient		Other:	4 Iduizing	Home 5 ☐ Res			pecify)	
E C	ding Aftar funa	ion	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	y Year)	28b. Time of Injury	28c.	Work?	t s 2 □ No	28d. Describe	how inju	ry occurred		
Division	ten feat tor: tha	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	urv - At hon	me farm stre			5 2 140	28f Location	Street ar	d Number or	Rural Route Numbe	0.0
á	in the	erti	4 Homicide determined	building, etc	c. (Specify))	ou, ractory, or			City or To	wn, State)	tarar ribata riarribe	D1,
	8 5 5 >	aic	29a. Certifier Certifying Phys	sician: To the best	of my know	vledge, death	occurred at t	he time,	date and pla	ice, and due to the	cause(s	and manner	as stated.	
	To tha Hos within 24 hi To tha Fun completely	ledical	(Check only 2 Medical Examilone)	and manner sta	t examination	on and/or inv	estigation, in	my opin	ion, death oc	curred at the time.	date and	d place, and di	ue to the cause(s)	
	To To	Σ	29b. Signature and title of certifier	91		^		icense n			29d. Da	te signed (Moi	nth, Day, Year)	
			verild ?.	Dem	er	mi		D 1	724	5	Jan	mary	5,200	ZC
ij	D		30. Name and address of person who co									0		
	Sta	te.	Gerald P. Sterner 31. Date filed (Month, Day, Year)	32. Registra	Signatu	es. Be			E., C	wings, M) 2	0736		
	Registr			6 2005	Weeve.	, K	bout	2						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 1AR Month - LORA 10:15 AM 05 09 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Mitchellville Villa Rosa Nursing Home Prince George's If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) April 1,1921 Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F Yrs. 83 203-07-1598 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No VA Arlington Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22204 USA 3501 S. 15th St. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🟋 No 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stella Black George Gering 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry G. Dettmar/Husband 3501 S. 15th St. Arlington, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) Arlin ton National 1/25/05 Arlington, VA Signature of Funeral S 22. Name and Address of Facility Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA 23a. Part1. Enter the disease, or complications that aused the deshock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause IFI and disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 1 ☐ Yes 2 ☐ No

29c. License number

ANNHOULIS

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

ettending physiclan

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

ို

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Machel Examinal Department or exciting a

Baltimore, Maryland 21215-0020

the burial-transi efter death. Director: After this certificate has been signed by the ettending pl I in by the funeral director, page 2 should be detached for use as i illed in by

or Attending Physician: The law requires that the death certificate be executed efter death.

Division of Vital Records, P.O. Box 68760.

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ANN Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Certification: To 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai

To the Hospital within 24 hours e To the Funeral C completely filled

1 CH AMO 31. Date filed (Month, Day, Year) State 2005

30. Name and address of person

of certifit

29b. Signature a

echupa Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

Registrar

			For State Registrar	State of M	aryland / De	partment ertificate			and M		giene No.2	005	01960
	- · · ·		1. Decedent's Name (First, Middle							2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Robert William							January	03,	2005	2128 P M
	Examin	er	4a. Facility Name (If not institution 1355 Fowler Ros				fown, or ings	Location o	of Death			ounty of Death vert Co	our tra
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthd	y) If Under 1		If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day			place (State or Foreign
	Director		171-36-1852	1₹M 2□F 5	8	Monuis	Days	riouis		March 8			nsylvania
	land low		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						1	0d. Inside City Limits
	e Man	ctor	MD Calver	rt County	Owings								1 ☐ Yes 2 X No
	with th	Funeral Director	10e. Street and Number	a a		10f. Zip (of What Cour	ntry?
	ns 234	erai	1355 Fowler Roa	12. Was Decedent	Ever in U.S. 1	3. Was Decede		spanic Orig	gin? (Spe	cify Yes or No-	U.S.	A . Race - Americ	an Indian,
9	after o	Fun	1 Never Married 2 Marri	Armed Forces? ied 1 ☐ Yes 2 📉 If Yes, Give	No	If Yes, speci		Specify:	, Puèrto	cify Yes or No- Rican, etc.)		Black, White,	etc.
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lical Examiner must be colliked at	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:	100 0								ite
15-	in 72 n "nat	Completed	15. Decedent (Specify only highes	t grade completed)	(G	cedent's Usual ive kind of work e. DO NOT use	k done d e retired,	ition <i>luring</i> mos <i>t</i>)	t of worki	ng	16b. Kind	of Business/Inc	dustry
212	d within giene. er than "	Com	Elementary/Secondary (0-12)	College (1-4or		wyer					Law	Firm	
pue	be filed htal Hygid od other evant, L	Be	17. Father's Name (First, Middle,							(First, Middle,		mame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the Health, or flems 23a or 28a-f show them 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Machinal Examiling or and linking at	2	Robert William 19a. Informant's Name/Relationsh		19b. M	ailina Address	(Street a			e Foley		own. State. Zin	Code)
	1 and 2 s Health ar sem 27 is		Annemiek DeVos	(Daughter)						Marylan			,
ore,	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation		20b. Place of Di	sposition (Namerematory or oth	e of	7	anua	Ty 5,	20c. Locat	tion - City or To	
Baltimore,	tment tant:		`4 □Donation 5 □ Other (Sp		Lee Cre	-		į		-		on, Mai	
Bal	permit. Pages Department of the Important: If Ite any injury or of once.		21. Signature of Indian Service	I	8	22. Name and			17GG				ert, P.A. MD 20736
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each li	d the death. Do not ne.	enter the mode	of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical	Ü	Immediate Cause (Final disease or condition resulting in death)	a. STAB	MOUND	Of		10 RX)				
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	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Under vin Cause (Disease or injury	b. Due to (or as	a consequence of):								
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9	death certificate be executed e attending physician and od for use as the burial-transit	9	10 000110	V									
Вох	leath certifica attending ph I for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pre					23d	I. Date of delive	ory Day Year
0	that the deleded by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 ☐ Other (spe	cify)			F W			
۵.	s that the ned by th e detache	by Ph	Part II. Other significant condition	ens contributing to death b	out not resulting in th	e underlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to th	ne cause of death?
ords	w requires that been signed b should be det									1 🗆 Y	es 2 🔼	lo 3∏Prob	ably 4 Unknown
Vital Records	2 2 2	Completed								24a. Was a autop:	sy	4b. Were autoprior to cordeath?	psy findings available apletion of cause of
tal	ician: The certificate harector, page	e Co	25. Was case referred to medical					OC Dinon	of Dogsth		2□No		2 No
	d is	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpa	tient 3 DO	Othe			ne 5 Resid		Other (Specify	SCENE
n of	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) Injui	e of 28	c. Injury Work	at ?	2	28d. Describe h	ow injury or	ccurred	YSELF
Division	tend death tor; the	icati	2 Accident investig	not be 200 Place of In	ury - At home, farm,			′es 2⊠N	_	Par Location (S			I Route Number,
Div	in Dir	Certification;	4 Homicide determine	building, et	c. (Specify)	street, ractory,	Oillog			City or Tow	n, State)		VINTS , nD
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical C		g Physician: To the best Examiner: On the basis of and manner st	of my knowledge, definition and/o				d place, a	and due to the c	ause(s) and	d manner as st	ated.
	To the within To the comp	Me	29b. Signature and title of certifier					number				igned (Month, i	
			▶ met				· C	. М.	t	70	awah	4,04,	2003
Ó	25	Long	30. Name and address of person	RUBIO, HD) 1		n St	reet,	Bal	timore,	Mary	land 2	1201
S.	Sta Registr		31. Date filed (Month, Day, Year)	1 1 2005	As Signature	Spen	es o						

			For State Registrar	State of Marylan	d / Dep		lealth and M	lental Hyg	iene 201	e. 05 nige	5 1
	Physici		Decedent's Name (First, Middle, L VICTORIA BAR			ranoato or	Douir	2. Date of Deat Month JAN .	Day Y	3. Time of Death	
	/Medio Examin		4a. Facility Name (If not institution, g NATIONAL LUTH	ive street and number)		4b. City, Town, o	or Location of Death	DAIV.	4c. County of		<u> </u>
	Funeral Director		5. Social Security Number 381-22-8649 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 ☐ M 2 ☑ F 92	last birthday, Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, DEC 16	Year) 9 1912	Birthplace (State or Forei Country)	ign
	e Maryland ta-f show tiffed at	ctor	10a. State 10b. County MD MONTGO		y, Town or L					10d. Inside City Limi 1 ☐ Yes 2 ☑	1
	th with the 23a or 28	Funeral Director	10e. Street and Number 23004 TIMBER (CREEK LANE		10f. Zip Code 20871		1	0g. Citizen of Wha	·	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Michal Examinar must be muitled at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eyer in U Armed Forces? 1Yes _ 2Ye If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.	
21215-0036	s within 72 ho plene. r then "natur the Modes!	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+) 2	(Give	dent's Usual Occup e kind of work done DO NOT use retire ISTERED	during most of work d)	ing	16b. Kind of Busin		51
Maryland 2	iould be filed I Menta! Hygl harked other hatic event, I	To Be C	17. Father's Name (First, Middle, Last PETER CHENCINS				18. Mother's Name MONICA	PIATKO	WSKI		
	and 2 sho salth and n 27 is ma		19a. Informant's Name/Relationship PETER DAVIO /	SON	2300)4 TIMBE	R CREEK	LA., C	, City or Town, Sta CLARKSBU	ure, Zip Code 20871	
Baltimore,	Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	sify) ST	Place of Dispo cemetery, cre	osition (Name of matory or other pla	URCH 1/13	Date	20c. Location - Cit		
Bal	permit. Departr Imports any off		21. Signature of Funeral Service Lic		Į	ZIII BE	UNERAL I	E RD.	BARNES	20838 SVILLE, MD	7
H	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	Due to lovas a conseq	uence of):		ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death	
8760,	te be executed ysician and te burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Of 3 no f Due to (or as a conseq	1 45	ter d	sea se			15 years	
P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	1		23d. Date o Month	. ,	
	w requires that s been signed b should be deta	Š	Part II. Other significant conditions Diobete	. 1 /		inderlying cause giv	ren in Part I.	23e. Did tob		ute to the cause of death? Probably 4 Unknow	wn
al Reco	iician: The law re certificate has be rector, page 2 sho	Completed						24a. Was ar autops perform 1 Yes 2	ned? dea	re autopsy findings availab r to completion of cause of th? Yes 2 \(\text{No} \)	ole of
Division of Vital Records,	ding After fune	Certification: To Be	25. Was case referred to medical examiner? 1	be an Disconfinite Ath	28b. Time of Injury	of 28c. Injur Wor M 1	y at k? Yes 2 \Bo	me 5 ☐ Reside 28d. Describe ho	nce 6 Other ((Specify) or Rural Route Number,	
ō	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying F	building, etc. (Specification) Physician: To the best of my known in the basis of examina	y) wledge, deat	h occurred at the tir	ne date and place	City or Town	, State)	ar as stated	
)	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	4malle Stated.	mo	29c. Licens		29	9d. Date signed (A		
	Sta	ite	30. Name and address of person who Samu EL G. 31. Date filed (Month, Day, Year)	. MALLER 32. Redistrar's Signa	m o	9701 V	EIRS DR.	ROCK	/ILLE,	MD 20850	
	Registi	ar	JAN 12	ZUUD PROPERT	M A	mark.					

			For State Registrar	State of Marylar		artment of H rtificate of L			gierre ()5	019	62
	Division	4	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	ath Day	Year	3. Time o	of Death
	Physici: /Medic		Dorothy Marie Decke	r				January 1			6:00	A. M
	Examin	er	4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. Count	of Death		
		ė	Calvert Memorial Hosp		to an blank star it	Prince Fre	derick If Under 24 Hrs.	O Data of Bird	Calver	-	101	
	Funeral		5. Social Security Number 6. S	□ M 200 F	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day	y, Year)	Coun	try)	or Foreign
	Director		489-28-3304 Usual Residence of Decedent	80				Dec. 17,	1924	Misso	uri	
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation	-			10	d. Inside (City Limits
	Man	to	Maryland St. Mary's	Lexi	ngton Pa	rk					1 K] Yes	s 2 □ No
	r 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	th wit		48941 Spring Lake D	rive		20653			USA			
	ems error	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi f Yes, specify Cuba				ce - America		
9	or It		1 Never Married 2 Married	1 ☐ Yes 2 XX No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:	,		y. White		
ĕ	ural',	d by	3 XWidowed 4 Divorced	Year or Dates:	10.5							
7	"nat	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work	ring	16b. Kind of E	usiness/ind	ustry	
2	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen				Own Ho	те		
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or Items 23e or 28e-f show ant, It is Madical Examples from the refilled at		17. Father's Name (First, Middle, Last,				18. Mother's Nam	e (First, Middle,	Maiden Sumai	me)		
an	a d d d	To Be	Thomas Alfred Maxwe	11			Cleo Bla	lock				
E Z	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is and Mental Hygiene is marked other than "natural", or fleens 23a or 28a-1 show an anaked other than "natural", or fleet mast be notified at an analic avant. If a Moultal East off er mast be notified at	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a	and Number or Rur	al Route Numbe	r, City or Town	, State, Zip	Code)	
Š	nd 2 alth a 27 ls		John Decker/Son		18909	Russell Ro	ad, Leonard	dtown, MD	20650			
Itimore,	ges 1 and 2 should t of Health and Men If item 27 Is marks or other traumatic		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		Date	20c. Location	- City or To	wn, State	
Ë	Page nent c int: If		1 ☐ Burial 2 反 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specil	Hemoval from State		n Crematory		7,2005	Arlingto	n. Vir	inia	
a	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 2002.		21. Signatur of Funeral Service Lice		22	. Name and Addres	s of Facility Mat	ttingley-	Gardiner	Funera		, P.A.
m	8 9 1 2 8		nichael Kevin	Hardene J	P.	O. Box 270	, Leonardt	own, Mary	land 206	50		
г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each lips.	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approxima Interval Be	tween
	Pnysician		Immediate Cause (Final disease or condition	Benit	stary	anest	+				Onset and	Death
	/Medical		resulting in death)	a Bue to (or as conse	quence of):	,						1
Ö	Examiner		Sequentially list conditions,	b. Caroli	ac ar	nest						
	sit sit	ine	if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury	Due to (or as a conse	quence or):					- 64		
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	guence of):							
8760,	cate be ex physician the buria	aiE										
687	phys the	edicai		_ d.								
×	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Da	ite of delive	γ	
Вох	death a atter	ciar	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			M	onth	Day	Year
<u>о</u> .	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown								
	es thai igned b	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	cause of	death?
ğ	w require been sig should b	ed	Hepat	tis				1 🗆 Y	'es 2□No	3 Proba	ibly 4 🗌	Unknown
S	aw re	Completed	- Hepati	alitis				24a. Was autop		Were autop	sy findings	available
m m	The lay	mo:						perfor	rmed?/	death?		2000
Ita	Physician: r this certifica ral director.	Bec	25. Was case referred to medical examiner?				26. Place of Deat					
<u></u>	hysic lidirə	101	1 ☐ Yes 20 No	Hospital: 1 Inpatient 2	ER/Outpatier	it 3□ DOA Othe	er: 4 ☐ Nursing Ho	ome 5 Resid	lence 6 🗆 Oth	ner (Specify)	
Division of Vital Records,	ng P		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe h	now injury occur	red		
sio	Attending r death. sctor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	Α			res 2 □No	206 Lti /6	20		DA At	
Σ	or At or At Dirac in by	Certification;	4 ☐ Homicide determined		nome, tarm, str ify)	eet, factory, office		28f. Location (S City or Tow		oer or Hurai	Houte Nun	nber,
Ц	pital ours a eral i		29a. Certifier 1 Certifying PI	nysicien: To the best of my kn	owledge death	n accounted at the time	o data and place	and due to the	navan(a) and m		tod	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		niner: On the basis of examin and manner stated.								s)
	o the o the o the o the o the o the o the o the	Me	29b. Signature and title of certifier		-	29c. License	number		29d. Date signe	d (Month, E	ay, Year)	
)	- s - 0		AmonDn	H MID		00	060120	,	1/1	6104		
1	220		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print) tal Road	4		1 1	0,00		
/	UN '		A. wall Hage	thmn 100	HOSPIT	tal Road	Prin	ce free	derick	, MD	20	678
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		· · · · · · · · · · · · · · · · · · ·					
	Regist	ar	JAN 1 9 2	005	1. A	alls						

			_ FOI	partment of Health and Mental Hygi	iene nos noss
			Tograna		ng. No. 000 01900
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year
1.00	/Medic		Nicholas Nabor Diaz, II 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	17, 2005 2:15 P M
	Examin	er	Bayside Care Center	Lexington Park	St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		9 Birthplace (State or Foreign
	Director		367-24-3623 /8	Apr. 18,	, 1926 California
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	Location	10d. Inside City Limits
	Maryl f sho	tor	Maryland St. Mary's Hollywo	ood	1
	r 28a	Directo	10e. Street and Number		Dg. Citizen of What Country?
	th with	al D	24155 John Cameron Way	20636	U.S.A.
	ems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte		1 ☐ Never Married 2 【X Married 1 ☐ XYes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 XYes 2 □ No Specity:	Specify:
9	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f show Ite Modical Examiner must be mulliked at	Completed by	15 Decedent's Education 16a Dec	Mexican Redent's Usual Occupation	Mexican 16b. Kind of Business/Industry
212	nin 72 In "ng Medik	piet	(Specify only highest grade completed) (Giv	ve kind of work done during most of working DO NOT use retired)	
2	ad with	Com	12 La	aborer	Construction
n	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	faiden Sumame)
Maryland 21215-0036	nould narke	٦		Mary Gonzales iling Address (Street and Number or Rural Route Number,	City or Tourn State Zin Code)
<u>B</u>	d 2 st th and 7 is n treur			55 John Cameron Way Hollywo	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "naturel; or Items 23e or 28a-f show expringing to other treumatic event, It s Medical Examiner must be multilated at once.		20a Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State
Baltimore,	Pages ent of nt: If i		1 🗆 Burial 2 Micremation 3 🗀 Hemoval from State	ield-Echols 1-23-05	Charlotte Hall, MD
<u>=</u>	mit. partm partm porta y inju				l Funeral Home, P.A.
<u> </u>	Depar Depar Impo eny ir			22955 Hollywood RD. Leonard	
			23a. Part1. Enter the disease, or completations that caused the death. Do not enshock, or heart failure. List only one cause of sach line.	enter the mode of dying, such as cardiac or respiratory arre	est, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	unemo	Onset and Death
ĭ	/Medical Examiner		Due to (or as a consequence of):		
Ь		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit	Examiner	Cause (Disease or injury		
ó	exec an and rial-tr	Еха	resulting in death) Last Due to (or as a consequence of):		T)
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	licai	d		
9	that the death certifice ed by the attending pl detached for use as t	Physician/Med	IF FEMALE:		
Box	ath ce	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fedal death 3	B Ectopic pregnancy Dispersion of the second	23d. Date of delivery Month Day Year
	he de / the a	ysic	1 Yes 2 No 9 Unknown	Conner (specify)	
P.O.	res that I signed by be detai		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tob	acco use contribute to the cause of death?
Vital Records,	quires n sign uld be	Completed by	Congestive Heart Failure Chro	nee Renal fail 1 Ye	s 2 No 3 Probably 4 Winknown
000	aw requir as been sl 2 should	piete	Andrew Milleton Sever Peris	pheral Vascular 24a. Was ar autops	
R	The ate h page	mo	COPD	perform	ned? death?
Ita	Attending Physicien: The in death. ector: After this certificate haby the funeral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one	9)
of <	Physic this co	ဂ္	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		
nc 0	ting F	ion	27. Manner of De th ☐ Nate of Injury ☐ Nate of Injury ☐ Nate of Injury ☐ Accident investigation 2 Accident investigation		w injury occurred
Division	Attend death ctor: y the	lical	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s	street, factory, office 28f. Location (Str	reet and Number or Rural Route Number,
<u>S</u>	after I Dire	Certification;	4 Homicide determined building, etc. (Specify)	City or Town	, State)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only (Ch		
	the H tin 24 the F nplete	fedical	one) and manner stated.		
	To To	Σ	29b. Signature and title of certifier	29c. License number 25	3d. Date signed (Month, Day, Year)
•					1/17/05
			James C. Boyd, M.D. 23415 Three	e, Print) Notch Road California_2061	, , , , , , , , , , , , , , , , , , ,
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrate Signature	Notes Road Carriothia 2001	
	Regist		JAN 2 0 2005	1 Proces	

			1 - For State Registrar	State of Maryland		artment tificate			ınd M	-	giene	200	5	019	64
	Physici /Medic		Decedent's Name (First, Middle, Last) Donald Willis Di	shrow						2. Date of De Month 01			9005	3. Time of 7:0	Death)8a M
X.)	Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location o	f Death		4c	. County o	of Death		
	Funeral Director	78	037 12 3300 A	7. Age (In yrs. last	<i>birthday)</i> 7 Yrs.	Leo If Under Months	narc 1 Year Days	f Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5-22-1	th	. Ma	ny s 9. Birthp Coun	lace (State or	r Foreign York
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation							1	0d. Inside Cit	y Limits
	Mary P-1 sh	tor	MD Carroll	Elde	ersbu	rg								1 🗆 Yes	
	or 284	Director	10e. Street and Number			10f. Zip	Code				10g. Ci	tizen of W	hat Coun	itry?	
	s 23a		7036 Macbeth Way				784				_Un:	ited			
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygens. Is marked other Hygens. Is marked other than "natural", or Itams 23s or 28s-f show aumatic event. It a Medical Erain as must be natified at	by Funeral	11. Marital Status 1 □ Never Married 2 ⊡ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Vas Decedi f Yes, spec I ☐ Yes 2		spanic Orig n, Mexican Specify:	jin? (Spe , Puerto f	cify Yes or No Rican, etc.))*		, White,		
Maryland 21215-0036	vithin 72 ho ne. han "natur e Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		(Give i	lent's Usua kind of wor DO NOT us	k done d e retired)	ition u <i>ring m</i> ost	of workin	ng		18b. Kind of Business/Industry			
2	filed w Hygier thar tl	CO	17. Father's Name (First, Middle, Last)	/	Pr	ofess		18 Mothe	r's Namo	(First, Middle,		Educa			
<u>a</u>	e d ta b	To Be	Elbridge Disbrow									Jumame	"		
ary	ss 1 and 2 should of Health and Men item 27 Is marks other traumatic	-	19a. Informant's Name/Relationship (Type	oe, Print)	9b. Mailin	g Address	(Street a			Potter		or Town, S	itate, Zip	Code)	
	1 and 2 Health am 27 I		Kathryn Asher/ Dau	<u> </u>	7036	Macb	eth	Way,		rsburg					
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Re	ceme	eterv, crem	sition (Nam natory or ot	her place	9)	D	ate	20c. L	ocation - C	City or To	wn, State	
			' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Conse	Brins	ilel	d-Ech Cre	ols	ry 1	-19-	-2005	Char	lott	е На	11, MU	
Ba	permit. Departr Importa any inju		Edward N. Brinstie						Bri	nsfiel					Α.
	Frysician	i Di	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition		o not ente	er the mode	of dying	such as o	cardiac or		carat.	QWII.	МП	Approximate Interval Betw Onset and D	reen .
R	/Medical Examiner		resulting in death)	Due to (or as a consequent	of):	- 1		•		1					10)
		e.	Sequentially list conditions, b	. Due to (ur as a consequence	en'of):	510V	1								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(()											
Ó,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a consequence	ce of):										
	cate b physic the bi	dicai		•											
O. Box 6	death certiff e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3 🗌	Ectopic pre						23d. Date Mont			ear
o.	that the ed by detact		Part II. Other significant conditions con	tributing to death but not resulting	a in the un	idertving ca	LISA CIVA	n in Part I		23e Did to	phaccou	isa contrib	oute to th	e cause of de	ath?
Records,	w requires that the been signed by th should be detache	eted by	- Myzantensian 1 Yes									Proba		nknown	
	The la ate has page 2	Completed							_	24a. Was autop perfo		de	ath?	sy findings av apletion of car No	vailable use of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3 DO	Othe			(Check only o	,			= 7/1/2	
on of	nding Physith:	-	27. Manner of Death Natural 5 Pending P	c. Injury Work	4 🗀 Nur	2	ne 5 🗆 Resid 8d. Describe h)				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the function completely filled in the function completely filled in the function completely filled in the funeral completely filled in the funeral completely filled in the function completely filled in the funeral completely filled in the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street, factory), office City or Town, 5							Street an vn, State	d Number	or Rural	Route Numb	er,	
	To the Hospital of within 24 hours and To the Funeral Ecompletely filled is	edical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	occurred a estigation,	it the time	e, date and inion, death	l place, a	nd due to the o	cause(s) date and	and man	ner as sta id due to	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	<i>y</i> .		29c.	License	number	07		29d. Dai	te signed	(Month, L	1.0	
			30. Name and address of person who con	mpleted duse of death (Item 23)	a) (Type, F	Print)	4	TO	()		10	anna	iy	1	2005
			Martin Thai	Mobiling	25	500	P	cint	OOK	ent	124	60	nar	you	MD
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature		e alle	,							7	LOG SO

			1 = For State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment of H rtificate of L	lealth and Death		20	05	01965
	Physic /Medi		1. Decedent's Name (First, Middle, L Mary S.	Evans				2. Date of De Month	Day	Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or		eath	4c. Count	y of Death	3:25 P M
	Funeral Director		Creighton Cent 5. Social Security Number 6. 164-10-7779	Sex 7. Age (In y	rrs. last birthday)		11ville If Under 24 H Hours M	in. 8. Date of Bird	th y, Year)	9. Birthp	eorge's
	D		Usuel Residence of Decedent 10a. State 10b. County		City, Town or Lo	ocation		Dec. 1	4, 1917	Penn	sylvania
	death with the Maryland me 23e or 28e-f ehow rinkel to trailled at	Director	Maryland Prince 10e. Street and Number	Georges		itchellvi 101. Zip Code	lle		100 000-00		10d. Inside City Limits 1 ☐ Yes 2 No
	e 23e o		10450 Lottsford				721		10g. Citizen of United		
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f show important: If item 27 is marked other than "natural", or iteme 23e or 28e-f show the figury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2器 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Rad Bla	ce - Americ ck, White, y: Whi	can Indian, etc.
Maryland 21215-0036	within 72 ho ane. then "natu	Completed	15. Decedent's Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of w	vorking	16b. Kind of B	usiness/Ind	dustry
nd 2	al Hygie t other vent, it	Be Co	17. Father's Name (First, Middle, Las	2	School	l Secreta		ame (First, Middle,	Educ Maiden Suman	ation	n
aryla	should b and Ment marked umatic e	To	James M. S1u 19a. Informant's Name/Relationship		19h Mailin			Norma Fuh	rer		·
_	s 1 and 2 f Health a flem 27 is other tra		Douglas Scott /	20b	11178	Kilkenny	Road,	Marshall,		ia 20	0115
Baltimore,	nit. Page artment o ortant: If injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Septice Lice	Removal from State	insfield	natory or other place 1-Echols (Cr. 1-2	0-2005 C	harlott	e Hal	11. MD
ä	Depariment Depariment Important Impo		Edward N. Brinsf	ield, Jr. MO	0032 229	JOS HOLLYN	vood Ro	rinsfield ad, Leona	rdtown.	1 Hon	ne, P.A. 20650-0279
A	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Out of the definition of th	ath. Do not ente	the mode of dying, Hailure	such as cardi	ac or respiratory arr	est,		Approximate Interval Between Onset and Death
68760,	death certificate be executed a attending physician and d for use as the buriat-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consecutive to (or as a consecutive to consecut	Arteny	disease	2				
Box 68	ath certi	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	tel death 3 □t	Ectopic pregnancy			23d. Date	of deliver	•
л Э	t the by th	Physi	1 Yes 2 Mo 9 Unknown	4□ Pregnant at time of 9□ Unknown		Other (specify)			Mon		Day Year
cords,	ped bed		Part II. Dther significant conditions of	71572	sulting in the und	derlying cause given	in Part I.	23e. Did tob			e cause of death?
He	The lar ate has page 2	e Completed	Cerebavascul	es Accidet	7			24a. Was ar autopsy perform 1 Yes 2	led?	eath?	sy findings available pletion of cause of
5	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient	3□ DOA Other:	-	ath <i>(Check only o</i> ne Home 5 ☐ Resider			
DIVISION	fter ng		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	t s 2 \(\text{No} \)	28d. Describe ho			
	lothe hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, stree	et, factory, office		28f. Location (Str. City or Town,	eet and Number State)	r or Rural F	Route Number,
:	ine Hosp in 24 hou the Fune poletely fil	edic	one)	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death of ation and/or inve	occurred at the time, stigation, in my opini	date and place ion, death occu	e, and due to the car arred at the time, da	use(s) and man te and place, ar	ner as state	ed. he cause(s)
	vit To To Con		29b. Signature and title of certifier	1		29c. License n	umber 7603		d. Date signed		
6	0	3	30. Name and address of person who William DuBovo				C		January		
	Stat Registra		William DuBoyo	32. Registrar's Sign	ature	LVILLE Rd.	. Suite	в 216 Во	wie, Ma	rylar	nd 20716

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 7, 2005 ar **Physician** Robert E. Fowler 2:20 P. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Landover Hills 4210 73rd Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F 217-46-8392 Director Feb. 6. 1947 Wash. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Wedgal Examiner must be notified at once. 10b. County 1 XYes 2 No **Funeral Director** Prince Georges Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4210 73rd Avenue 20784 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Carpenter Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Fowler Ruth English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5706 83rd Place, New Carrollton, Maryland 20784 John C. Fowler - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 01-11-05 Brentwood, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metastati **Physician** disease or condition resulting in death) /Medical Examiner 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2× No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 5 Residence 2 6 ☐Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule an title of certifier 0 who completed cause of death (Item 23a) (Type, Print) Hanner Parkway Greenbelt, Maryland, 20770. Sajeev Anand, M.D. 7343-A State JAN 1 1 2005 Registrar

		For 1_ State	Type or Print in Black In State of Maryland / Dep							
		Registrer		rtificate of	Death		Reg. No. 200	5 0 1 9 6 7		
Physici	an	Decedent's Name (First, Middle, Last	,			2. Date of De		3. Time of Death 8: 284 M		
/Medic		4a. Facility Name (If not institution, give	P. Fleming	4h City Town	or Location of Dogth	Janua	4c. County of E			
Examir	er	Doctor's Comunity H	i i		or Location of Death anham		Prince Ge			
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Bin	th 9	Birthplace (State or Foreign		
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land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits		
with the Maryland a or 28a-f show Le rotified at	ţċ	Maryland Prince Geo	orge's	Bowie				14 Yes 2 No		
ith the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha			
death w	- E	4622 Runningdeer W			20720		U.S.A.			
after de or Itam miner n	Funeral	11. Marital Status 1 ☐ Never Married 2XXMarried	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2XXNo	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - A Black, V	American Indian, White, etc.		
urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 yo	Specify:		Specify:	Black		
n 72 hours after death with the Marylar "natural", or Itams 23a or 28a-f show sitical Exarrient must be notified at	eted	15. Decedent's Ed (Specify only highest gra		dent's Usual Occup	pation during most of work	rina	16b. Kind of Busin	ess/Industry		
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uld be Aental rkad tic av	To B	Nathanie.	l Pierce		1	Vaxine Day	у			
2 sho and h is ma		19a. Informant's Name/Relationship (er, City or Town, Sta	te, Zip Code)		
1 and Health am 27 thar tr	l y	Mr. Royald T. Fleming 20a. Method of Disposition	20b. Place of Disp		r Way Bowie	, Marylan Date				
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natu any injury or other traumatic avent, the Medical ODGS.		1 ☑ Burial → ☐ Cremation 3 ☐	Removal from State Roll Fami	matory or other pla Ly Ceretery	ce)		20c. Location - City 05 Roanoke			
nit. P. artme ortani injury		 4 □ Donation 5 □ Other (Specify 21. Sign rure of Funeral Service Licenter 		2. Name and Addre	an of English		.0-1.			
Dermi Depa Impo any id		Vilmen K.			K		neral Home, n, D.C. 200			
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The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of	delivery		
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Physicia this cert al direct	2	1 Yes 2 7 M6	Hospital: 1 Inpatient 2 ER/Outpatie	nt 31210UA	ner: 4 Nursing Ho		dence 6 Other (Specify)		
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in Signal	Certification:	4 Homicide determined	building, etc. (Specify)			City or Tov	vn, State)			
id solution		29a. Certifier 1 Certifying Ph	ysicien: To the best of my knowledge, deal niner: On the basis of examination and/or in	th occurred at the time	me, date and place,	and due to the	cause(s) and manne	r as stated.		
Hospital	.≝ !	CONCER ONLY ZEEMWOOLGAI EXAM	MITTER OF CIT CITO DESIGN OF OXERITIFICATION AND OF IT	ivostigation, in the c	spiritori, doctri occur	od at the tille.	date and place, and	due to the cause(s)		
To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens			29d. Date signed (M			

State

Registrar DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

The son who completed cause of death (Item 23a) (Type, Print) LUCK Rd

MDD 51398

Jan 08, 2005

Lanham, MD 20706

			1 - For State Registrar	State of M	arylan	•	artment rtificate			nd Me	, ,	iene eg. No2	005	01968	
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physici /Medic		Marv	Wil	ma	Fl	iss				January		005	12:30 p ^M	
	Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City, T	Town, or L	ocation of	Death			nty of Death		
			Calvert Memorial	Hospital			Pri	nce 1	Frede	rick		Ca	alvert		
	Funeral		Social Security Number 6. S		e (In yrs.	last birthday)	If Under 1 Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. Birthp	place (State or Foreign	
L	Director		568-32-6161	□M 2 ∑ F	76	Yrs.	WOILIIS	Days	Tiodis	141111.	Mar 10,	1928	Geor	gia	
	pu ,		Usual Residence of Decedent		10- 03	T-mail and a									
	show	L	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits	
	Ba-1 s	cto	MD Calve	ert			Nort	h Be	each					1 X Yes 2 □ No	
	or 28	Oire	10e. Street and Number				10f. Zip (Code			1	0g. Citizen o	of What Cour	ntry?	
	23a	ail	4006 1st Street					2071	4			τ	USA		
	ems erns	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decede	ent of His	panic Orig Mexican,	in? (Spec	cify Yes or No- tican, etc.)		lace - Americ		
9	or it		1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No		1 Yes 2		Specify:			Spec	cifu:		
21215-0036	hours after death with the Maryland turat', or ttems 23a or 28a-1 show al Erana, or rough be routhed at	d by	3 X Widowed 4 □ Divorced	Year or Dates:									· WII	ite	
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pu	d tal	Be	17. Father's Name (First, Middle, Last,						18. Mother	's Name	(First, Middle, I	Maiden Sum	ame)		
yla		2	Edward John	Willia	ams				Mar		Agnes		Dickso		
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (**							Route Number		vn, State, Zip	Code)	
	C = 0 L		Debra M. Fliss, d	aughter					et, N		Beach,		20714		
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. F	Place of Dispo cometery, crei	sition (Name natory or oth	e of her place,)	Da	ite	20c. Location	n - City or To	own, State	
Ĕ	Pa men ant: ury		'4 □ Donation 5 □ Other (Specif		So	. Memo:	rial G	arde	ns (01	1–13-	-2005	Dunk	irk, N	1 D	
alt	permit. Departr Imports any inj		21. Signature of Funeral Service Licer	nsee		22	. Name and	Address	of Facility						
m	80 = 8 8		William K	(ress			Rauscl	h Fur	neral	Home	e, P.A.	, Owi	ings,	MD 20736	
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89	ficate p physics the l			- v											
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. E	Date of delive	erv	
B	atte	clar	in the past 12 months?	1□Live birth 4□Pregnant a]Ectopic pre] Other (s <i>pe</i>					1	Month	Day Year	
o.	at the de by the a	ıysı	9 Unknown	9□ Unknown				. ,,							
<u>α</u>	that led by deta		Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderlying ca	use giver	in Part I.		23e. Did tot	acce use co	ontribute to th	ne cause of death?	
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Vital	or Attending Physicien: Th ther death. Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only on	e)			
of	Physical this call direction	2	1 Yes 2 No	1 🗹 Inpatie		ER/Outpatier		_	4 1401		e 5 🗆 Reside			()	
2	ding F h. After funera	0	27. Many r of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		c. Injury a Work?			3d. Describe ho	w injury occi	urred		
Division	death. ctor: A y the fu	Certification:	2 Accident investigatio				М		es 2□N						
.≥	pr Ati ter d irect n by	THE STATE OF	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At he c. <i>(Specif</i>	ome, farm, str	eet, factory,	office		28	3f. Location (St. City or Town		nber or Rura	I Route Number,	
Ω	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A bletely filled in by the fu														
	Hospital 24 hours a Funeral I tely filled	edical	29a. Certifier (Check only 2 Medical Exar	i ysician: To the best niner: On the basis o	of my kno f examina	wledge, deatl	occurred a	t the time	, date and	place, ar	nd due to the ca	use(s) and r	manner as st	ated.	
	To the Hos within 24 h To the Fur completely	ledi	one)	and manner st	ated.										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	\mathcal{Q}	10	4	~	License			2	9d. Date sign	1	Day, Year)	
			houmar	ce fol	1500	AVI	I	TIL	168)		1110	107		
			30. Name and address of person who	completed cause of c	leath (Iten	n 23a) (Type,	Print)								
	D		Kioumarce Yazdar		2555	Solom	ons I	s. Ro	d., N	., H	untingt	own, M	1D 206	39	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	Signa	ture					_				
	Registi	ar	JAN 1	2 2005	Tentus	w 15.	GOSA	Carlo							

State of Maryland / Department of Health and Mental Hygien@ [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Jimmy Clinton Flynt January 10 2005 1026 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 JM 2 □ F Months Days Director Washington DC 579-42-4099 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examinating must be invitited at 1 Yes 2 XNo Director Huntingtown Calvert Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20639 1270 Plum Point Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Store/Retail Store Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Lasley Bernes Flynt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1270 Plum Point Rd. HUntingtown Maryland 20639 James Flynt-son 20b. Place of Disposition (Name of cometery, crematory or other place) Jan 21 2005
Maryland Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Cheltenham Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Hone 4405 Broomes Island Rd. Fort Republic MD 20676 t enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL HEMORRHAGE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed OBSTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 Yes 2 □ No 25. Was case referred to medical examiner? Hospital or Attending Physician: Be (26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number D40370 10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrate Sonature

DHMH 17 Rev 1/2001

State

Registrar

Genevas &

JAN 1 1 2005 >

			State of Manuard / De		
			4 Chair	partment of Health and Mer <i>ertificate of Death</i>	2005 01030
			Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death 3 Time of Death
	Physic		William	1-1/0	Month Day Yeer
	/Medi Exami		4a_Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			The Johns Hopking Hospital	Battinone Ci	L
	Funeral		5. Social Security Number 6. Sex 7. Age (Inlyrs. last birthda		Date of Birth (Mooth Day Year) 9. Birthplace (State or Foreign
	Director		217-36-3277	Jays Hours Will. Ja	Date of Birth (Morth, Day, Year) an 21, 1938 9. Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Mary -1 sh	ţō	MD Calvert	Chesapeake Beach	1 ∑ Yes 2 ⊡ No
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	11 with 23 0 0 15 1 Le	by Funeral Director	8214 E. Street	20732	USA
	ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 14. Race - American Indian,
36	s afte	y Fu	1 Never Married 2 Married 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1 N	1 ☐ Yes 2 No Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show hs Medical Examinative notified at		Year or Dates: 1956-62		Specify: white
5	in 72 " ra	Completed	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
212	filed withi Hygiene. ther than ont, the M	E O	College (1-40r 5+)	eat cutter	grocery stores
פ	e filed al Hygic other vent,	Be C	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Sumame)
/lar	should be nd Mental marked o	To	Edwin Arthur Fowble	Cora Vic	ola Gill
Maryland	and and is m	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural Ro	
	1 and Health lem 27 other tra			4 E St., Chesapeake I	Beach, MD 20732
Ore			20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ Removal from State 20b. Place of Dis	position (Name of Date rematory or other place)	20c. Location - City or Town, State
Ë			'4 □ Denation 5 □ Other (Specify) Metropo	litan Crematory 01-06	6-05 Alexandria, VA
Baltimore,	permit. Page Department of Important: If any njury or once.		1 1 1 9	22. Name and Address of Facility	
	40240			Rausch Funeral Home,	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac or res	Spiratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Sophageal Cancer	Unkacul
ш	Examiner		Due to (or as a consequence of):		241
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	mle.	DIS
	od d ansit	Examiner	Cause (Disease or injury that initiated events	inferction	6her
o,	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
8760,	9 8	licai	d		
9 ×	law requires that the death certifica as been signed by the attending ph. 2 should be detached for use as th	Med	IF FEMALE:		
Вох	ath catternation of the us	Physician/M		☐Ectopic pregnancy	23d. Date of delivery Month Day Year
P.0.	that the de ed by the a detached	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)	World Day 16al
٣.	res that th igned by be detac		Part (). Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Records,	tuires sign Id be	Ω			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
S	w requir s been s should	olete			24a. Was an 24b. Were autopsy findings available
œ	0 - 0	Completed			autopsy performed? performed? performed? death?
		e)	25. Was case referred to medical	26. Place of Death (Che	□ Yes 2♥ No 1□ Yes 2□ No
	d is	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		5 ☐ Residence 6 ☐ Other (Specify)
n of	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury Injury	of 28c. Injury at 28d. I Work?	Describe how injury occurred
Si Si	Attending r death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No	
É	in Site	Certification;	4 Homicide 4 Homicide 4 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
_	portal ceral l		29a. Certifier 127 Certifying Physician: To the best of my knowledge dea		10.1 (3.2) (4.2)
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) and manner stated	th occurred at the time, date and place, and di rvestigation, in my opinion, death occurred at	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
	vithin capi	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	7 3		I was	RES-MOD	
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	January 2, 2005 4 more MD 21087-100
11	2+1		Michael Banks MD 60 North	Wife Steet R.	4 more MD 21287-70
	Sta	(C.	31. Date filed (Month, Day, Year) 32. Registray Signature	1 .	7
	Registra	ar	JAN 0 6 2005> Blown &	Sperker	

74R10N

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:45 PM January 15, 2005 John Louis Fischer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 44644 Smiths Nursery Road St. Mary's Hollywood If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 17, 1938 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**₺** M 2□ F 076-30-7228 66 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Maryland St. Mary's Hollywood 1 ☐ Yes 21X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 44644 Smiths Nursery Road 20636 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 1956 'netural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi. h and Mental H 7 Is marked oth Be Mary Haberl John Fischer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 Is
any injury or other trau Martha Ann Fischer Wife 44644 Smiths Nursery Rd. Hollywood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metropolitan Crematory **Jan 20,2005** Alexandria, Virginia ' 4 ☐ Donation 5 ☐ Other (Specify) ²², Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licensee uchaels 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METAMATIC RENAL CARCINOMA Pnysician 31/3 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 🗌 Yes 2 110 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗌 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ell D50606 1020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) point look our Ro Leonard foun S. COUROLEP LHHABRA 25500 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 10a, b, c, d, e, f per fh 9840 2-1-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day 2005 JANE ELIZABETH SEWARD GATTENS 7, JANUARY 13:00 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT CHESTER RIVER MANOR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUGUST 21, 1924 MA **Funeral** 1 ☐ M 2 🗓 F 219-18-9145 Director 80 Yrs. Usual Residence of Decedent deeth with the Maryland 10b. Counting Anne's 10a. State MD 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic svent, the Medical Evantinar must be notified at Price Delaware Yes ZLING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road General Delivery 19904 21656 1203 Walker USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. white is 1 and 2 should be filed within 72 hours after c of Health and Mental Hygiene. Item 27 is marked other than "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Florence C. Aller Henry M. Seward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) General Delivery Price Maryland 21656 Catherine Marie Gattens/ dau. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or oti 1 ☐ Burial 2 ☐ Xemation 3 ☐ Removal from State 1/8/05stevensville, MD ¹ 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation Cntr 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Kul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No 2√No 1 Yes 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 Alatural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) nananan 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar 1 2005

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma			of Health a of Death	and Mental Hy	giene Reg. No. 20 (05 01975
F	Physicia /Medic	al	Decedent's Name (First, Middle, Last) FREDERICK SARGANT 4a. Facility Name (If not institution, give s			4h City Toy	wn, or Location of	2. Date of De Month JANUAR	Day Y	2,00
	Examin Funeral Director	er	FREDERICK MEMORIA 5. Social Security Number 6. Sex	L HOSPITA	L (In yrs. last birthday) 86 Yrs.	FREDER	ICK		FREDE	
	within 72 hours after death with the Maryland one. ene. then "neturel", or items 23e or 28e-f show he Medical Evarning mast be rutified at	Director		erick	10c. City, Town or Lo	F:	rederic	k	10.00	10d. Inside City Limits 1 ☐ Xes 2 ☐ No
	ter death with the Marylan Items 23a or 28a-f show increast be nutified at	Funeral Din	10e. Street and Number 7987 Windsail Co	12. Was Decedent E	Ever in U.S. 13.	10f. Zip Co Was Decedent	21701	gin? (Specify Yes or No , Puerto Rican, etc.)		. S . A . American Indian, White, etc.
21215-0036	72 hours after neturel', or It	by	1 Never Married Married 3 Widowed 4 Divorced	1V Yes 2 N If Yes, Give J A Year or Dates: Mar cation	n 1943 to ch 1946	1 Yes 2 dent's Usual O	No Specify:		Specify:	White
N	ges 1 and 2 should be filed within 72 hours afte t of Health and Mantal Hygiens in eleuret, or I if item 27 is marked other then "neturet, or I or other treumetic event. It a Mudicul Exami	e Completed	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5- 2	+) life.	ecutive		t of working or's Name (First, Middle,	Charitat	ole No-Profit
	2 should be and Mental is marked o reumetic eve	To Be	Daniel Arthur 19a. Informant's Name/Relationship (Ty, Mary Jo Gorman/Wi	oe, Print)			reet and Numbe	Alice Knee	dler er, City or Town, St	ate, Zip Code)
e,	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 1 Burial 2X Cremation 3 R. 4 Donation 5 Other (Specify)		20b. Place of Dispo	osition (Name o	of	Jan. 21, 20	20c Location - Ci	
Balti	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Furreral Service License	Bacfa		T 06 Eas	st Churc	sford Funera ch Street,	Frederick	, MD 21701 Approximate
	Inysician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin	e.	1	rens	Seps	3	Interval Between Onset and Death
	e be executed sician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
. Box	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregn □ Other (specif			23d. Date of Month	,
I Records,	The faw requires ate has been sign page 2 should be	Completed by Pl	Part II. Other significant conditions con (UP) ASCUT AUCTO STANO Kulane Stane	tributing to death bu	at not resulting in the u	inderlying causi ITASTY others	e given in Part I.	1 \(\) \(\	es 2 No 3 an 24b. We pric	ute to the cause of death? Probably 4 Unknown are autopsy findings available or to completion of cause of ath? Yes 2 No
u .	Attending Physicien: Thr r death. sctor: After this certificate by the funeral director, pag	ation: To Be	27. Manner of Death 1—Natural 5 — Pending 2 — Accident investigation	ospital: Inpatier 28a. Date of Injur (Month, Day		f 28c.				
Divis	To the Hospitel or Attending Phywitin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral.	ai Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc	of my knowledge, deat	h occurred at th	ne time, date an	City or Tow	m, State)	or Aural Aoute Number, er as stated.
4	To the Hc within 24 I To the Fu completely	Medical	29b. Signature and title of certifier	er: On the basis of and manner stal	examination and/or in ted.	vestigation, in a	my opinion, deal cense number D1642	th occurred at the time,	29d. Date signed (d due to the cause(s)
i	Sta Registr	te	,	ne III, M	eath (Item 23a) (Type, D., 300 W	est Nin		et, Frederi	ck, MD 2	1701

			1 - For State Registrar	State of Ma	ryland /		artmen tificate			and Me		giene leg. No 2005	01976
П	Physici	an	1. Decedent's Name (First, Middle, Last		-						2. Date of Dea Month	Day Year	
	/Media	cal	Joseph S. H	uffman, II	<u>T</u>		4h Cihi	Town or	Location of		anuary	2, 2005 4c. County of Dea	3:00 A M
	Examir	ier	2237 Harley Drive				40. City,		kirk	Death		,	vert.
	Funeral Director		5. Social Security Number 6. Se 229–22–4328	x 7. Age	(In yrs. last 79	birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. 8 Min.	Date of Birth (Month, Day	9. Bit (2. 1925 Was	rthplace (State or Foreign ounty) shington, DC
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	oum or La	antion				451	1, 1020	
	shov	ō	MD Calve			nkir							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28e-1	rect	10e. Street and Number	1			10f. Zip	Code	-	-		10g. Citizen of What C	ountry?
	h with	ID IE	2237 Harley Drive					20	754			USA	
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 ie marked other then "naturel", or Items 23e or 28e-f show other treumatic event, it a Medical Evenination could be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		13.	Was Deced f Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		
21215-0036	rel', or	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:)		1□Yes 2	№ No	Specify:			Specify: W	hite
2-0	72 hc natur	Completed	15. Decedent's Edi (Specify only highest grad		1	(Give	tent's Usua kind of wor	к доле а	<i>lurina</i> mosi	t of working		16b. Kind of Business	s/Industry
121	within ene. then	Juno	Elementary/Secondary (0-12)	College (1-4or 5+) B		ing E					Apartment	Building
d 2	Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)				8	8		r's Name (First, Middle,	Maiden Sumame)	201101118
Maryland	should be nd Mental marked o umatic eve	To B	Joseph S. Huffm	an, II					Th	nelma		To	oxey
Nan	12 sho		19a. Informant's Name/Relationship (T)				-				Route Numbe irk, M	r, City or Town, State,	Zip Code)
	Jes 1 and 2 of Health if item 27 or other tre		Margaret Huffman 20a. Method of Disposition	(MTIE)	20b. Place	e of Dispo	sition (Nan	ne of				d 20754 20c. Location - City or	r Town, State
mon.	m O		1 🛣 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		1	-	natory`or of Vete		-	200	.ry <u>-r</u> 2	Cheltenham	
altimore,	permit. Page Department Importent: If eny injury o		21. Signature of Funeral Service Licens		3							l Home Cal	
8	89 5 8		23a. Part1. Enter the disease, or comp								nd Blv		, MD 20736
	Priysician /Medical Examiner	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a	consequen		mal s	, (زمد	Dun			Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit			d	040011								MILE III
O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal de	ath 3□	Ectopic pro Other (sp					23d. Date of de Month	l Nivery Day Year
ecords, P.	g de	by	Part II. Other significant conditions co	ntributing to death but	not resultin	ng in the u	nderlying ca	use give	en in Part I.		23e. Did to	baeco use contribute t es 2□No 3□P	o the cause of death?
α	o £ 0	Completed									24a. Was a autop: perfor	sy prior to death?	utopsy findings available completion of cause of
Vital	yeicien: Th	Bec	25. Was case referred to medical examinar?						26. Place	of Death (Check only or		
of V	d is	ို	1 Pres 2 □ No	Hospital: 1 Inpatient		Outpatier		_	4 🗀 I Nu			ence 6 Other (Spe	ecify)
	ding h.	tlon	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	M	Bc. Injury Work 1 □ 1	at (? /es 2 □ !		d. Describe in	ow injury occurred	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home (Specify)	, farm, str	eet, factory	, office		28	f. Location (S City or Tow	treet and Number or R n, State)	lural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner state	xamination	dge, death and/or in	occurred a	at the tim in my op	e, date and pinion, deal	d place, an th occurred	d due to the c at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	Λ			29c	License	number		2	29d. Date signed (Mon	th, Day, Year)
			Krommares	L You	Sdow	ni	D	00	1710	28		114105	
			30. Name and address of person who c	ompleted cause of dea	ath (Item 23	a) (Type,	Print)	. —). 1	\supset	11 4	11	all Day m
	2+1		31. Date filed (Month, Day, Year)	AMNI MD 32. Registra	Signature		olomun	5 <i>15</i>	alsand	Kd.	N Nu	ntinatown, 1	40601
	Sta Regist			6 2005	Meres	K	Loca	the o					

			1 - For State Registrar	State of Maryl		artmen <i>rtificat</i>			nd M		iene _{eg. No.} 2 (005	01977
	Physici		1. Decedent's Name (First, Middle, L Helen E.	ast) Hawkins						2. Date of Deal Month January	Day	2005	3. Time of Death 10:20 P M
	/Medic Examir		4a. Facility Name (If not institution, g			4b. City,		Location of	Death		4c. Cou	nty of Death	George's
	Funeral Director		5. Social Security Number 6. 577-24-6515 Usual Residence of Decedent	Sex 7. Age (In)	yrs. last birthday) 83 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min	8. Date of Birth (Month, Day, Jan. 6,	^{Year)} 1921	9. Birthi Cou Was	place (State or Foreign http) Sh., DC
	th the Maryland or 28e-f show	Director	10a. State 10b. County	George's	City, Town or L		tland	1		1	0g. Citizen o	of What Cou	10d. Inside City Limits 1 Tyes 2 No ntry?
920	n 72 hours after death with the Maryland "netural", or Items 23a or 28e-f show official Examiner must be notified at	by Funeral	5508 Vernon 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever i Armed Forces?		Was Deced If Yes, spec		20756 spanic Origin, Mexican, Specify:		ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
Baltimore, Maryland 21215-0036	within ene. than "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th	Education rade completed) College (1-4or 5+)	16a. Dece (Give life.		rk done a se retired	ation during most of ewife	of worki	ng		Business/In	,
yland 2	should ba filed and Mental Hygid s marked other umatic avant, II	To Be C	17. Father's Name (First, Middle, Las Herbert Z						's Name	(First, Middle, Marth		ame)	
, Mar	ss 1 and 2 sho of Health and itam 27 is my cothar traum		19a. Informant's Name/Relationship Herbert S. Haw	kins - Son	5.	508 Ve	ernor			iFland.	950		Code)
imore	Page ment o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	b. Place of Dispo cemetery, cre incoln	matory or o Memori	ther place La1 (Cem. 1	/11	/2005	Suit	land,	
Balt	permit. Departi Import any inj		21. Signath e of Funeral Service Lice	Stewart I		4001	Benr	ning R	Rd.,	ewart Fu N.E. Wa	sh.,)19
	rnysician /Medical		23a. Part f. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	ry Arte				ardiac c	r respiratory arre	est,		Approximate Interval Between Onset and Death 10 Hrs.
	Examiner	-C	Sequentially list conditions,	Due to (or as a con Cardia b. Due to (or as a con	c Arrytl	nmia							10 Hrs.
o,	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate date. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <u>Seizur</u> Due to (or as a con	e Disord								5 Years
68760,	leath certificate be attending physicia I for use as the bu	l edicai		d	onal Dis	sorder	<u>-</u>						5 Years
.O. Box	the c y the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	etal death 3	⊒Ectopic pro ☐ Other (sp					C.F.	Date of delive Month	ery Day Year
Records, P	requires een sign nould be	d by	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying ca	ause give	on in Part I.			es 2 XNo		ne cause of death?
Vital Rec	The lar ate has page 2	e Compiete	25. Was case referred to medical					OC Disease		24a. Was as autops perform 1 Yes 2	y ned? ! ∑ No	b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
of	ding Phys h. After this funeral di	ation: To B	examiner? 1 Yes 2 \(\overline{\text{V}} \) No 27. Manner of Death 1 \(\overline{\text{V}} \) Natural 5 \(\overline{\text{Pending}} \) Pending 2 \(\overline{\text{Accident}} \) Accident investigati	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury		8c. Injury Work	or: 4 [XNurs	sing Hor	ne 5 Reside 28d. Describe ho	nce 6 🗆 C		y)
Division	Pafte in Diri	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d building, etc. (Sp	ecify)					28f. Location (Str City or Town	, State)		
	4 4 4 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	ledicai	(Check only 2 Medical Exa	Physician: To the best of my aminer: On the basis of examend and manner stated.	knowledge, deat nination and/or in	h occurred ivestigation,	at the tim , in my op	e, date and inion, death	piace, a occurre	and due to the ca ed at the time, da	use(s) and late and place	manner as st e, and due to	tated. the cause(s)
	To the twithin 2 To that Complete	M	29b. Signature and title of certifier	MD	7		. License	number 24535		29	-	ned (Month, nuary	Day, Year) 6, 2005
R	6			. Berwa, M.D.	7700 0		nch	Ave.,	#C-	-101, C1	inton	, MD	20735
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 0 20	95 Registrar's S		de							

CPM 05-00342 Kyle Hooper

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	DI		1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Your	3. Time of Death
	Physici /Medic		Kyle James Hooper		January 1	²⁴ , 2005	16:58 м
	Examin		4a. Fecility Name (If not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederic	ck	4c. County of Deat Calvert	h
Š	Funeral Director		5. Social Security Number 216 35 9785 Cusual Residence of Decedent 6. Sex 1 2 7. Age (In yrs. last birthday) 12 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 1	9. Birt 7 1992	hplace (State or Foreign nuntry) Maryland
	death with the Maryland me 23e or 28e-f show r must be notified at	ctor	Maryland Calvert 10c. City, Town or Loc. Lusby	ation			10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
	ath with the 23e or 28 ust be not	Funeral Director	10e. Street and Number 1156 Cordova Drive	10f. Zip Code 20657		Citizen of What Co nited S	
036	ours after al', or ite Examine	þ	1 Never Married 2 Married 1 TYes 2 No	las Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto I Yes 2 ho Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: wh	e, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, any injury or other traumatic evant. The Madical Ex. 2010.	Completed	(Specify only highest grade completed) (Give kilfe. Di	ent's Usual Occupation ind of work done during most of workir O NOT use retired) 1dent	ng 16b	. Kind of Business/	Industry
land 2	uld be filed Mental Hygi irked othar itic evant, I	To Be Co	17. Father's Name (First, Middle, Last) Ronald Lewis Hooper		(First, Middle, Maid ynn Hil		d
	and 2 sho balth and I of is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Ronald Lewis Hooper- father 1156 Co	Address (Street and Number or Ryra ordova Drive Lusb	Route Number Ci y, Maryla	nd 20657	Típ Code)
Baltimore,	Pages 1 announce of the sent of the sent of the sent of the cury or other		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ★ ☐ Donation 5 ☐ Other (Specify)	ition (Name of atory or other place) emetery January 19		Location - City or arstow Ma	
Balti	permit, Departn Importe any inju		N KIDA K	Name and Address of Facility Rails 5 Broomes Is. rd.	usch Fune		20676
To the last	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocarditis Due to (or as a consequence of):	r the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (154354 or ir jury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	certificate be executed iding physician and ise as the burial-transit	ical	Due to (or as a consequence of):				
.O. Box 68	ath certifi attending for use as	by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ecords, P	w requires that the de been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		1	the cause of death?
\mathbf{r}	The lay ate has page 2	Completed			24a. Was an autopsy performed	? prior to death?	topsy findings available completion of cause of 2 No
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
on of Vital	ng fter iner	tlon: To	27. Manner of Death 1 Matural 5 Pending 1 Inpatient 241 En/Outpatient 242 En/Outpatient 243 En/Outpa		ne 5 Residence 8d. Describe how in		cify)
Division	al or Attending safter death. I Diractor: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		8f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause ad at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the Comp	M	29b. Signature and title of certifler	O.C.M.E.		Date signed (Month) nuary 15,	
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	enn Street, Balti	more, Mar	yland 212	201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8. Tinte of Death **Physician** Month Sylvia Phyllis Hall /Medical 11:55 P.M 2005 January 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1675 Mallard Point Road Prince Frederick
If Under 1 Year | If Under 24 Hrs. Calvert 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days 1 M 2 LF Director 67 Yrs. MaryTand 220 34 7835 April 4 1937 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1675 Mallard Point Road Items 23a 20678 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo þ 3 Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H la marked oth Be 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Heatth and Mental Important: If Itam 27 I a marked t any injury or other traumatic ev. QDC8. Harold Bowen Lola Muriel Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle D. Hall - daughter 1675 Mallard Point Rd. Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery Jan 10 2005 Parstow Maryland 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Furneral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Homora Priysician Concer 7 yearn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attanding Phyaician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐ Pregnant at time of death Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, director, page 2 should Completed 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DQA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. after death 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0027189 1000 30. Name and address of person who completed cause of death (Item 2Ba) (Type, Print) Solomons Island Rd. Huntingtown, Md. 20639 2417 YousAf 31. Date filed (Month, Day, Year) 32. Registra/s Signature State JAN 1 1 2005 Registrar

			1- State of Maryland / De State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygie		01980
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		David Keith Heil		January	9, 2005	10:50 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		٠	16020 Marlboro Pike	Upper Marlboro		Prince Geo	orge's
	Funeral Director		5. Social Security Number 453-64-1036 6. Sex 7. Age (In yrs. last birthd) 65 Yrs	Months Dave Hours Min	8. Date of Birth (Month, Day, Y	9. Birth Col 1939 Texa	nplace (State or Foreign untry)
			Usual Residence of Decedent		DCPL 3,	1757 ICA	45
2	how		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Σ α	a Miles	cto	Maryland Prince George's Upper Ma				XXYes 2 □ No
it ti	or 2	Director	10e. Street and Number	10f. Zip Code		. Citizen of What Co	untry?
y dte	s 23e	eral	16020 Marlboro Pike 11 Marital Status 12. Was Decedent Ever in U.S. 1	20772 3. Was Decedent of Hispanic Origin? (Sp	US.	A 14. Race - Amer	ican Indian
tar de	item	Funeral	11. Marital Status 1. Mas Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 1. Married 2. Married 1. Married 2. Married 1. Mar	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
. I Z I D-UUSO within 72 hours after death with the Maryland	F. O	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1959-63	1 ☐ Yes 2 ☐XNo Specify:		Specify: Whit	te
ار ار	ne fr	ompleted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	king 16	b. Kind of Business/I	
Z id	than so	du	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		Compostur	_
א ל	Hygie ther int, II	ပို	17. Father's Name (First, Middle, Last)	Carpenter 18. Mother's Nam	ne (First, Middle, Ma	Carpentry	У <u> </u>
/land	lental rked o tic eve	To Be	Henry Harry Heil	Thelma	Fougeron	,	
Mary	and N is ma suma			ailing Address (Street and Number or Ru		,	'
e, e	Health em 27 ther tr		20a Method of Disposition 20b. Place of Di	O Marlboro Pike Up		c. Location - City or 1	
	nt: If it		1 Burial 2 Noremation 3 Removal from State	crematory or other place) Janu	ary II,	denton, Ma	
Saltimor	Department of Health and Mental Hygiene. Importent; or items 23e or 28e-f show eny injury or other traumatic event, It e Madical Examination ust be rediffied at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Going Home Cremati	on Service	e P.O. Box	784
			23a. Part1. Enter the disease, or complications that caused the death. Do not	Beverly L. Heckrot enter the mode of dying, such as cardiac			Approximate
В	hysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	oned			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):				
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7	isit is	nine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury) Due to (or as a consequence of):				
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STOU,	physician and the burial-transit	dical	d				
	ng ph	Med	IF FEMALE:	- ma			
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5	- C - B	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
ords, P.O	should be detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	been sign				1 ☐ Yes	2□No 3□Pro	bably 4 Dinknown
() 3 () ()		ompleted			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	ate h	Com			performed	d? death?	2 No
VITAL	is certificate director, pag	Be (25. Was case referred to medical examiner?		th (Check only one)		
OT VITA	S D	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			e 6 Other (Spec	ify)
_	h. After th funeral	ertification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Tim. Injur		28d. Describe how	injury occurred	
DIVISION	ector: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm.		28f. Location (Stree	nt and Number or Rui	ral Route Number.
בַּבְ	s after	Certi	4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide		City or Town, S	State)	
Hoenii	within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, did not be the set of my knowledge, did not be the s	eath occurred at the time, date and place, rinvestigation, in my opinion, death occur	and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
4	Within To th	Me	29b. Signature and title of certifier	29c. License number	-	Date signed (Month	, Day, Year)
	2,- 0		29b. Signature and title of certifier (12 -)	1005694	9 1	19/05	~
11)	2		30. Name and address of person who completed cause of death (Item 23a) (Ty	De, Print) KAHAKSHI	BAIGHE	5	
	-01		1 6620 CRAIN HWLL, STE 31. Date filed (Month, Day, Year) 32. January	Joseph LA PLA	ITA . I	(1) 20	646
	Sta Registr		31. Date filed (Month, Day, Year) JAN 12 2005 32. Engistrar's Signature	Spertis			

			1 - For State Registrar	State of N	Maryland		artment			and M	lental Hy	2			019	81
		The state of the s	Decedent's Name (First, Middle,	Last)			imoute	0, 2	- Cuin		2. Date of De	Reg. Ne.	00		3. Time o	f Death
	Physici /Medic		Mary Agnes	Hammett							Month January	Day 17,	200	Year 5		0 AM
	Examin		4a. Facility Name (If not institution,		r)		4b. City,	Town, or	Location of	f Death			County o			
	ЩП	(1)	23621 Budds C					Lemer				S	t. M	ary	s	
	Funeral Director		216-24-1560	3. Sex 7. A 1 ☐ M 2 🖾 F	Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bir (Month, Da July 3	th 1, 19	913	Cour	olace (State of ntry) yland	or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							1	I 0d. Inside C	ity Limits
	Mary -f sh	tor	Maryland St. M	ary's	C1	Lemen	ts									2 X No
	h the	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of Wh	nat Cour	ntry?	
	th will		23621 Budds C:	reek Road				2062	24			USA	A			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces d 1 ☐ Yes 2 X If Yes, Give Year or Dates	?] No	1	Vas Decede f Yes, spec I ☐ Yes 2		spanic Orion, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1		Americ White,		
Maryland 21215-0036	nin 72 ho n "natur Wedical	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual kind of worl DO NOT use	k done di	tion uring most	of worki	ing	16b. Kin	d of Busi	iness/ln	dustry	
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pu	be file tal Hy d othe	Be	17. Father's Name (First, Middle, La						18. Mothe	r's Name	(First, Middle				udo er y	
yla	Meni Meni Marke Marke	P	Claude Euger									Abell				
Mai	d 2 st th and 7 is n traun		19a. Informant's Name/Relationshi Sarah Jean Pingl								I Route Numb			tate, Zip	Code)	
ē,	Heal Heal tem 2 other		20a. Method of Disposition	eton Dau	ghter 20b. Place	e of Dispo	O. Box sition (Nam	e of	-		s, MD	2062 20c. Loca		ity or To	wn, State	
OE.	Pages ent of nt: ff i		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		Sacre	etery, cren ed He	art C	her place emet	ery¦J	anua 2005	ry 19				ryland	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Li			22	Name and Matti	Address ngle	of Facility	din	er Fune	ral H	lome.	, P.	Α.	
			23a. Parti. Enter the disease, or co	omplications that cause	ed the death. (P.O. er the mode				nardtow or respiratory a) 2(0650	Approximat	е
	Physician		Immediate Cause (Final disease or condition	nry one cause on each	canu										Interval Bet Onset and i	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequen	ce of):										
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or a	s a consequen	ce of):										
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
o,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last		s a consequen	ce of):										
8760,	ate be hysici the bu	dlcal		d												
Box 6	death certificate be executed e attending physician and ed for use as the burial-transit	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					***		-	23	d. Date of	of delive	rv	
o.	that the death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown		2 ∏ Fetal death at time of death		Ectopic pre Other (s <i>pe</i>						Month		•	/ear
S, D	law requires that the as been signed by the 2 should be detache	by Pr	Part II. Other significant condition	s contributing to death	but not resultin	g in the ur	derlying ca	use giver	in Part I.		23e. Did to	obacco use	ontribi	ute to th	e cause of d	eath?
rds	w requires that been signed I should be det	ed b									101	/es 2 □	No 3	☐ Proba	ably 4 🔣	Inknown
Record	e law re has be	Completed									24a. Was		24b. We	re autor	osy findings	available
	The cate ha	Сош									perfo	rmed?	dea	ith?	npletion of ca 2□ No	1026 01
Vita	ician: sertific actor,	Be	25. Was case referred to medical examiner?	I tanaitali						of Death	Check onl o	ne)				
of	Phys this ral dir	P .	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpat		Outpatient		-	4 🔝 Nur		ne 5 K Resid			(Specify)	
on	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Date)	ay Year)	Injury	M	c. Injury a Work? 1 □ Ye	at es 2 □ N		8d. Describe h	iow injury o	occurrea			
Division of Vital	Attendi or death. ector; A by the fu	Certification:	3 Suicide 6 Could no	be 28e. Place of In	njury - At home	, farm, stre					8f. Location (S	Street and I	Number	or Rural	Route Num	ber,
	rs after al Direction by	Cert	4 - Rouncide	bullding, e	tc. (Specify)						City or Ton	m, State)				
		Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best aminer: On the basis of and manner s	of examination	dge, death and/or inv	occurred al estigation, i	t the time	, date and nion, death	place, a	nd due to the ded at the time,	cause(s) ar date and pl	nd mann lace, and	er as sta d due to	ated. the cause(s)	
	To the within To the Comp.	Ž	29b. Signature and title of certifier				29c.	License	number			29d. Date s	signed (/	Month, L	Day, Year)	
			1 XSh	M	1		i.	242	597	-		1-1	7-05	5		
5	55		30. Name a pardress of person with Jeffery Brown,					town	, Ma	ry1a:	nd 2065	0				
	Stat Registra	3	31. Date filed (Month, Day, Year) JAN 18	32 Regist	rar's Signature		of s						-			

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last	State of N	Maryland		artmen rtificate					Reg. No.	105	01982
	Physici /Medi Examir	cal	Willia 4a. Facility Name (If not institution, give	m Jones	r)	P 294 U/4	4b. City,	Town, or	Location		Month	IARPAY 9	Inty of Death	<u> </u>
	Funeral		5. Social Security Number 6. Se 24 2 - 24 - 46 52 15		Age (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da Feb. 2	th ay, Year)		timore unlace (State or Foreign untry) th Carolina
	Director show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Baltin	nore		Town or Lo		Ralt	imore		reb. 2	, 1924	Nor	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the	Funeral Director	10e. Street and Number 3002 Essex Road				10f. Zip		2123			10g. Citizen	of What Co	*
9600	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liems 23a or 28a-f show may night of other traumatic event. The Madical Examples could be notified at ance.	þ	11. Marital Status 1⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 文 Yes 2 [If Yes, Give Year or Dates	s? 7 No	6	1 ☐ Yes 2	2₩ No	Specify:		ecify Yes or No Rican, etc.)		Race - Amer Black, White ecify: B	
2121	filed within 72 I Hygiene. other than "nati ent, the Medice	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) Seven	cation le completed) College (1-40	r 5+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us unkno	k done d e retired) WN	uring mos			16b. Kind o	unkno	
	should be find Mental Harked of	To Be	17. Father's Name (First, Middle, Last) unkno			19b. Mailir	na Address				(First, Middle, unk	nown		in Code)
	ages 1 and 2 ant of Health are: If item 27 is		Marjorie Fonder 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		e cen		alden sition (Nam natory or ot	Cypi e of her place	ress	Cour	t, Wood	llawn,	Maryl	and 21207
Baltimore,	parmit. Popartme Important any injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen's		or Se	22 L	Name and	Address Pat	s of Facilit	on &	Son Fund 219	neral	Home.	
	Medical Examiner	ilcal Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a CARD I) Due to (or a CARD I) Due to (or a CARD I)	ed the death. line. MYDC s a conseque AC AR s a conseque MIC C s a conseque	CARDI Ince of): RREST Ince of). CARDI	AL II	NFAI	RCTI		r respiratory a	rrest,		Approximate Interval Between Onset and Death
.O. Box 6	The law requiras that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe						Date of deliv Month	rery Day Year
ords, P.	w requiras that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death	but not result	ing in the ur	nderlying ca	use give	n in Part I.		23e. Did to	V		the cause of death?
		Completed	Of Warring day do not died								1 Tes	osy rmod? 2. No	b. Were autoprior to condeath?	opsy findings available impletion of cause of
ō	ding Phys h. After this funeral dii	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	1 Inpat 28a. Date of Inj (Month, D	ury 2 a <i>y Year)</i>	WOutpatient 8b. Time of Injury	28 M	Cther	r: 4□ Nui	rsing Hon	Check onl one 5 Resided. Describe h	dence 6 🗆 C	curred	
É	ipital or ours afte ieral Dir filled in I		4 Homicide determined 29a. Certifier 1 Certifying Physics	sician: To the bes	etc. (Specify)	edge death	occurred a	t the time	e, date and	d place, a	City or Tow	m, State)	mannor as a	al Route Number,
	To the To the Comple	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier	and manner s	oi examination	ii and/or inv	29c.	License	number	n occurre		29d. Date sign	ned (Month,	
	Sta Registr		30. Name and address of person who co XIAO ZHOU. M. D. 31. Date filed (Month, Day, Year)	7601	death (Item 2	R DR		TOW	JSON.	MAF	YLAND		7.5	, , ,

.16	Jackson		1 - For State Registrar	State of Maryland /		artment of I rtificate of		nd Men		7111	15	01983
	Dhyois		Decedent's Name (First, Middle, Last	it)					ate of Dea			3. Time of Death
	Physic /Medi		Tyrone Jack					Jå	onth nuary	7 88, 20	0 05 ′	18:50 M
	Exami	ier	4a. Facility Name (If not institution, give 5010 Indian Head I	street and number) Highway		4b. City, Town, o		Death		4c. County		eorge's
	Funeral Director		212 11 4230	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 2	Hrs. 8. D	ate of Birth Month, Day,			place (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation						10d. Inside City Limits
	a-f sh	tor	MD Prince (Georges Oxon	Hil	1						1 Yes 2 No
	or 28	Olrec	10e. Street and Number			10f. Zip Code	•		1	0g. Citizen of V	Vhat Cou	ntry?
	sath w	eral	741 Audrey Lane		1	20745				JSA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 Is marked othar than "natural", or Items 23a or 28a-f show any injury or othar traumatic avant, I'm Neulical Examinar must be invilled a once.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates:	i	Vas Decedent of H f Yes, specify Cub □ Yes 2X No	lispanic Originan, Mexican, I Specify:	n? (Specify \ Puerto Ricar	Yes or No- n, etc.)	Blac	e - Americ k, White, - Bla	
15-0	"natu	letec	15. Decedent's Ed (Specify only highest grad	ucation 16a de completed)	. Deced	lent's Usual Occup kind of work done OO NOT use retire	ation during most o	f working		16b. Kind of Bu	siness/In	dustry
121	within lene. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retire borer	d)			Const	ruat	ion
	2 should be filed within and Mental Hygiene. Is marked other then aumatic avant, The Mental Auma	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's	Name (Firs	t, Middle, N	Maiden Sumam		1011
ylar	should by and Menta	ToE	Robert A. Drehe				Vone	tta J	Jacks	on		
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (T) Vonetta Jackson	/Mother		g Address (Street						
	Health tam 27 othar tr		20a. Method of Disposition	20b. Place of	of Dispos	Barnaby sition (Name of		E.,Wa		gton, I 20c. Location -		
OE.	Pages nent of int: If it		1∑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State cemete	ary, crem	atory or other plac	´ I				-	
Baltimore,	permit. Pages Department of Important: If if any injury or c		21. Signature of Funeral Service Licens	TICOUL	22.	tion Ce Name and Addre	m 1/	14/20 reene	U5 C	lintor	Iomo	aryland
8	20 E 2 9	7 19	Yelson E/	Tree of	814	<u>4 Frank</u>	lìn S	t. Al	exan	dria.V	7A 2	2314
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o		not ente	r the mode of dyin	g, such as ca	rdiac or resp	iratory arre	est,		Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			15 (2)	to 7	X50				Onset and Death
	Examiner			Due to (or as a consequence	of):							
	ם ב	iner	Sequentially list conditions, it my least products cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a consequence	Oty.							
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	of).							
68760,	lificate be executed g physician and as the burial-transit			Due to (or as a consequence	or):							
_	E G	ledical										
Вох	attending for use	an/N	200. Was decedent program	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □	Ectopic pregnancy				23d. Date	of delive	ry
0.	The law requires that the death cer. Ite has been signed by the attendin age 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown		Other (specify)				Mon	th I	Day Year
Δ.	es that igned by be deta	by Ph	Part II. Dther significant conditions cor	ntributing to death but not resulting i	n the und	derlying cause give	en in Part I.	23	3e. Did toba	acco use contril	oute to the	e cause of death?
Records,	w require been sig should b							_	1 🗌 Yes	2 2 No :	B □ Proba	ably 4 Unknown
ecc	law r	Completed						24	a. Was an autopsy		ere autop	sy findings available
al H	(0 17							10	perform	ed? de	ath?	2□ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? XYes 2 □ No	fospital: 1 □ Inpatient 2 □ ER/Ou		3CT DOA Othe	26. Place of		1			
J Of	ig Phy ter this neral o	H 46	27. Manner of Death	28a. Date of Injury 28b. 1	Time of	28c. Injury Work	4 Nursir			ce 6 XOther		ect was
sior	Attanding r death. actor: After by the funer	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation		njury 150 f	OM 1 1	res 2 XNo		shot		ردس	ed mas
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stree	et, factory, office		28f. Loi Cit	cation (Stre	et and Number State) 5/1/1	or Rural	Route Number, an Head
Ц	a Hospital or Attanding Pl 24 hours after death. a Funeral Diractor: After the telegive filled in by the funeral		29a. Certifier 1 ☐ Certifying Phys	Silician: To the best of my knowledge	eet	anured at the time	- data d l	MUUY	· UNOY	1 mum	(1)	
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only one) Medical Examin	ner: On the basis of examination and manner stated.	d/or inve	stigation, in my op	e, date and pl inion, death o	ace, and due ccurred at th	e to the cau ne time, dat	ise(s) and mani e and place, an	ner as sta id due to t	ted. the cause(s)
١	To tha within 2. To tha I complet	Ž	29b. Signature and title of certifier	/		29c. License	number		290	d. Date signed	(Month, D	ay, Year)
. Λ			Yamel Touth	all, MD			.M.E.		Ja	nuary (7, 2	005
1	- (4)			mpleted cause of death (Item 23a) (Mall, MD 112	Type, Pr L Pe	nn Stree	t, Bal	timore	. Mar	vland 2	1201	
	Stat	_	31. Date filed (Month, Day, Year)	Registrar's Signature	4.				,	,		
45	Registra	1	JAN 1 1 2005	Marie . M. 1	-	7,						,

			1 - For State Registrar	State of M	aryland / Dep	artment of		Mental Hy	211114	11986
			Decedent's Name (First, Middle, L.	ast)			Doutin	2. Date of De		3. Time of Death
	Physic /Medi				OLEDA			JANU A	ARY 5 200	r
4	Examir	ner	4a. Facility Name (If not institution, gr			4b. City, Town,	or Location of Deat	h	4c. County of De	ath
	Funeral		Heron Point - 5. Social Security Number 6.	Chesape	ake Wing ge (In yrs. last birthday	Ches	tertown	8 Date of Bir	Kent	irthology (State or Familia
	Director		084-09-2890 Usual Residence of Decedent	1 X M 2□F	92 Yrs.	Months Days		8. Date of Bi (Month, Da Jan 1	7 1912 Ve	irthplace (State or Foreign Country) : rmont
	show		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary 1-f sh	tor	MD Kent		Cheste	rtown				1 X Yes 2 □ No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
	ath wi	ral	1012 Heron Po	int		2162	20		U.S.A.	
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	o- 14. Race - An Black, Wh	nerican Indian,
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. do other then "nature!', or Items 23e or 28e-f show event, the Madical Eventies rust by mailing at	by	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 250 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣 No			Specify:	White
2-0	72 hor	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	s/Industry
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retir	e during most of wor ed)	King	Book Bin	ding
	filed withi Hygiene. Ither ther			4	Mecl	nanical			Manufact	_
Maryland	should be filed within and Mental Hygiene. marked other then imatic event, I're M	Be c	17. Father's Name (First, Middle, Las Alphonse Kole						, Maiden Sumame)	
Z.	2 should and Me is mark	은	19a. Informant's Name/Relationship		19b. Mail	na Address (Stree	·	Mishuc	er, City or Town, State,	Zin Code)
	es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumatic e		Sarah Beall	(daught		Box 1			MD. 216	
ore,	es 1 a of He of He fitem		20a. Method of Disposition		20b. Place of Disp			Date	20c. Location - City of	
Ë	Page ment o ent: If ury or		1 ☐ Burial 2 XI Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci		Kent Cr		· 1	/05	Smyrna, 1	DE.
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot 2000.		21. Signatura of Funer 1 Service Level	0/	G 00510 11	2. Name and Addr 11ena Fi 8 West	ess of Facility Ineral H	ome of	Stephen	L. Schaech
			23a. Part1. Enter the disease, or con shock, or heart/failure. List only	plications that caused	the death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Car	enume o	1 lens	^			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		5			
		er	Sequentially list conditions,	b. Due to (or as	a consequence of):					
	uted d ansit	Examin	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	an andrial-tra		resulting in death) Last	Due to (or as	a consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai		_ d						
9 ×	ertific ling pl	Φ.	IF FEMALE:							
Вох	death certific e attending p d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	ïy		23d. Date of de Month	Day Year
O.	the the	ysic	1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of death 5L	Other (specify) _				
Ω_	es that the igned by be detact	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Vital Records,	= 000							12	Tes 2□No 3□P	robably 4 DUnknown
000	aw as b	ompieted						24a. Was		utopsy findings available
<u> </u>		Com							rmed? death?	completion of cause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital			26. Place of Dear	th (Check only o	ne)	Need at ad
o	this al dir	To.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		IL SLIDOA			dence 6 Other (Spe	Assisted Living
0	Attending F r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Wo		28d. Describe n	now injury occurred	
	Attend r death ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ıry - At home, farm, str			28f. Location (S	Street and Number or R	ural Route Number,
ā	tel or s afte el Dir	Certification;	4 Homicide	building, etc	c. (Specily)			City or Tow	m, State)	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best on miner: On the basis of and manner sta	examination and/or in	occurred at the tivestigation, in my o	me, date and place, opinion, death occur	and due to the d red at the time, o	cause(s) and manner a date and place, and du	s stated. a to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of cedifier	7	-	29c. Licens		- 2	29d. Date signed (Mon	· '
)			> / Mules				060301		1/6/05	-
			30. Name and address of person wh	mpleted cause of de	eath (Item 23a) (Type,	AO NEWS	CAN	064-2	10 A	A 2 2 -
		, proje	31. Date filed (Month, Day, Year)	VYIEVI W	s Signature	סובפונ וייט	2107	CUTUSIE	thour, N	11) 21620
	Sta Registra		JAN 0	6 2005	Sac M	Annal .				-

			1- For State of I	Maryland / Departmer Certificat	t of Health and Me e of Death	ental Hygien Reg. N	_ 0 0 0	01985
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Yum Soo Ki M			2. Date of Death Month D	7 2005	3. Time of Death
	Examine Funeral Director	ner	4a. Pacility Name (If not institution, give street and number Montgomery Ceneral 5. Social Security Number 6. Sex 7 228 2773.23 12 M 2 F	Hospital O	Days Hours Min.	8. Date of Birth (Month, Day, Yea	Movilgon Birth 25. 17	place (state or Foreign gity)
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County M.D. M.D. County	10c. City, Town or Location			,	10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	th with the 23e or 28s	Funeral Director	10e. Street and Number 1	10f. Zip	Code 20902	10g. C	Citizen of What Cou	intry?
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. ad other then "naturel", or Items 23e or 28e-f show event, I've Medical Evarting must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Order	nt Ever in U.S. 13. Was Dece If Yes, spe No 1 □ Yes	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
21215-0	C 2 39	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	life. DO NOT u	rk done during most of working	g 16b.	Kind of Business/Ir	ndustry
Maryland	Mer Mer arke	To Be	17. Father's Name (First, Middle, Last) Young Kim	/ (20 M X	In Sa	(First, Middle, Maide	ing	
	1 and 2 s Health ar 8m 27 ls ther trau		19a. Informant's Natifie/Relationship (Type, Print) Sung HEE KIM (Dave 20a. Method of Disposition	19b. Mailing Address 77 (0 E) 206. Place of Disposition (Na)	(Street and Number or Rural	ndale	Va 220	003
Baltimore,	Page nent o ant: If ary or		1 Surial 2 Cremation 3 Removal from Star 4 Donation 5 Other (Specify) 21. Signature of Europa Service Licensee	Faulux Mam	ther place)	15 Fa	Location - City or T	VOL VERAL SERVICE
B	permit. Departr Imports any inji		23a. Part 1. Enter the disease, or complications that cause	12303	KAYOK DR	Upne n	. 1	MD 20772 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	eymonia	o or dying, duon as cardiae or			Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions bb.	s a consequence of): K 5 D, Sea Se s a consequence of): **The sea Sea Market Sea Sea Market Sea Sea Sea Sea Sea Sea Sea Sea Sea Sea	with Demi	antia	5	many years many
68760,	ficate be executed physician and is the burial-transit	dical Exa		s a consequence of):	uen pre	047 31		years
. Box	death certi e attending id for use a	by Physician/Me		e of pregnancy 2			23d. Date of deliv Month	rery Day Year
	es be	ted by Pr	Part II. Other significant conditions contributing to death	but not resulting in the underlying o	ause given in Part I.			the cause of death?
Œ	The ate his page	e Completed	OF Was and otherwise and other			24a. Was an autopsy performed? 1 Yes 2 X N	prior to co	opsy findings available impletion of cause of 2 No
Vital	Physicien: r this certific ral director,	OB	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	ient 2 ER/Outpatient 3 DC	26. Place of Death Other: 4 D Nursing Hom	(Check only one) e 5 Residence	0.500	
J of	ng Phy ter thi	T :uc	27. Manner of Death 28a. Date of In	ury 28b. Time of 2		3d. Describe how inj		ry)
Division	l or Attendir after death. Director: Af In by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be	ijury - At home, farm, street, factory	1 Tes 2 No	Bf. Location (Street a City or Town, Sta		al Route Number,
۵	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier (Check only one) 29 Medical Examiner: On the basis	of my knowledge, death occurred	at the time, date and place, ar	nd due to the cause(s) and manner as s	stated.
,	To the I	Medical	one) and manner s 29b. Signature and title of certifier	tated.	License number		ate signed (Month,	
LA -	11		By he hend	2 0	0021033	Ja	nuam 8	, 2005
K	Sta	te	30. Name and address of person who completed cause of By Oung L. C. 31. Date filed Month, Day, Year) 32. Regis	death (Item 23a) (Type, Print) M. D. 13000 Ge rar's Signature	orgio Avenue	. Silversp	vinz Man	, 2005 ulmo/20906
	Registra	1	JAN 1 0 2005 Beeck	In the same				

			1- For State Registrar	ate of Maryland / Dep	partment of Fertificate of			ene 0 0 5	01986
	Physic		1. Decedent's Name (First, Middle, Last) Zewin Wesley	Lively.			2. Date of Death Month	Day Year	3. Time of Death
	/Med Exami		4a. Facility Name (If not institution, give street. 7456 Shortall S	treet	4b. City, Town, o	or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 197-09-3818	7. Age (In yrs. last birthda 88 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	Year) 9. Birth Cou 1916 M	place (State or Foreign ntry)
	the Maryland 28a-f show	'n	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits 1 □ Yes 2 No
	r 28a-f	Director	MD KENT 10e. Street and Number	CHESTE	RTOWN 10f. Zip Code		100	g. Citizen of What Cou	
	23a or	al D	7456 SHORTALL ST	REET	21620)		USA	,
	Items	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
9600	rel', or	þ	If Y	ned Forces?]Yes 2 ZNo es, Give ar or Dates:	1 □ Yes 2 No	Specity:		Specify: BL	
21215-0036	thin 72 ha e. en "natu Medical	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Co	leted) 16a. Dec (Giv life.	edent's Usual Occup le kind of work done DO NOT use retired	nation during most of work d)	ing 16	6b. Kind of Business/In	dustry
2			9th	- '	STRUCTIO			LOCAL 19	99
Maryland	og a a og og og og og og og og og og og og og	To Be	17. Father's Name (First, Middle, Last) CASPER BROWN				e (First, Middle, Ma		
ary	d 2 should ith and Men 7 is marke treumatic	-	19a. Informant's Name/Relationship (Type, Pri	nt) 19b. Mai	ling Address (Street		LANCHE al Route Number, (LIVELY City or Town, State, Zip	Code)
	f Health item 27 other tre		BRENDA WICKES-DAUG		POESTWI	CK LN N		LE, DE 19	
Baltimore,	200		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Remova	THOM State	ematory`or other plac	(e)		c. Location - City or To	own, State
altin	그 돈 은 글 .		* 4 ☐ Pocation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		EL U.M. 22. Name and Addres	1/8/		OMONA, MI lley Fune) vnol
ñ	Depa Depa Impo any ir		> to yee O. Wa	lley(WOOO26)s	ervice 8	321 W. S	t. Anna	polis. MI	21401
			23a. Fant. Enter the disease, or complications thick, or heart failure. List only one caus	that call sed the death. Do not er e on each line.	iter the mode of dyin	g, such as cardiac o	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ve to (or as a consequence of):	with a	sryllen	15.	K	epid
	Examiner			ao to (e. do d'outoquotico bi).					
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of):					
oʻ	cate be executed hysician and the burial-transit	Exal	reculting in death) Leet	ue to (or as a consequence of):					
8760,		dical	d						
9 x		/Mec	IF FEMALE: 23c. If ye	s, outcome of pregnancy					
.O. Box	The law requires that the death certific tite has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months?	Live birth 2 ☐ Fetal death 3 {	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	Day Year
oʻ Oʻ	es that igned by be deta	by Ph	Part II. Other significant conditions contributing	g to death but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
Records,	w require been sig should t	ted	O Severe peripher	al arterial	trose	ee i	1 ☐ Yes	2 No 3 □ Prob	abiy 4 □Unknown
		Completed by	(4) Cat protate	tus & Hypera	nelestin	leme	24a. Was an autopsy performer	d? prior to cor death?	osy findings available inpletion of cause of 2 No
Vital	certific rector,	Be	25. Was case referred to medical examiner?			26. Place of Death			
	ding Phys h. After this c funeral dir	. To	1 ☐ Yes 2 ☐ No Hospital: 27. Manner Ceath 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatien Date of Injury 28b. Time o		4 Nursing Hon	ne 5 Desidenc 8d. Describe how	e 6 Other (Specify)
ion .	death. ctor: Afte / the fune	atlor	1 in atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work	?` ′es 2 □ No	.50. 5030/150 /104	injury coodined	
Division of	ire ire	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At home, farm, strouilding, etc. (Specify)	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rura State)	Route Number,
	vithin 24 hours at To the Funerel D completely filled in	edical	[Officer of the Control of the Contr	o the best of my knowledge, deat the basis of examination and/or in manner stated.	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
	Withi To th		29b. Signature and title of certifier	MAD	29c. License	number 2./3/3	29d.	Date signed (Month, I	Day, Year)
			30. Name and address of person who completed	cause of death (Item 23a) (Type.	Print)	Chart		13/05 mo 216	20
	Stat	.6		32. Registrar's Signature	1 - The	.) com	wown/		- 0
	Registra	r	JAN 0 3 2005	James St.	9000				

			Ot-t-	partment of Health and Nertificate of Death		2000	0100
	•		Registrar 1. Decedent's Name (First, Middle, Last)	Fillicate of Death	Reg. 2. Date of Death	Ne UU5	3. Time of Death
	Physici /Medic		Lawrence Edward Lunsford, Sr.		January	1 2005	12:35 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Southern Maryland Hospital 5. Social Security Number 6. Sexy 7. Age (In yrs. last birthda)	Clinton (1) If Under 1 Year If Under 24 Hrs.	O Date of Birth		George's
	Funeral Director		578-14-5837 1 1 2 □ F 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 24	Coun	lace (State or Foreign try) ash., DC
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or limited to the county				
	Maryla f sho	ro	Maryland Prince George's		`	11	0d. Inside City Limits 1 → Yes 2 → No
	n the	Irec	10e. Street and Number	Clinton, MI		Citizen of What Coun	Λ.
	23e c	ral D	5937 E. Boniwood Turn	20735		United S	States
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-1 show other traumatic event, the Michael Examinational De notified at	by Funeral Director	I Never Married 2 Married 1 ZAYes 2 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	etc.
21215-0036	urel',	d by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: B	Lack
-5	in 72 n "net	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b	b. Kind of Business/Ind	lustry
212	giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+)	PEPCO - Plant Wo	rker	Priv	ate
pu	ould be filed with Mental Hygiene. arked other than atic event, the N	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid		
Maryland	should I	2	Trigger Lunsford 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	in Address (Otto Local)	Elsie (U		
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, the Mang.e.			ing Address (Street and Number or Rura 937 E. Boniwood Tur			
altimore,	es 1 a of Hez litem r othe		20a. Method of Disposition 20b. Place of Disp	osition (Name of amatory or other place)		n MD 207 Location - City or Tox	
<u>m</u>	Pages ment of lite		'4 Denation 5 Other (Specify) Lee's	rematory 1/10/		Clinton,	MD
Bal	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee	 Name and Address of Facility St 4001 Benning Rd. 			19
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shook, of heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	Š W	Immediate Cause (Final disease or condition resulting in death)				Onset and Death
	/Medical Examiner		Due to (or 1s a consequence of):	4 . 1 4.		13	
	1.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	act intection		-	
	acuted ind transit	Examine	that initiated events				
8760,	cate be executed physician and the burial-transit		Due to (or as a consequence of):				
687	ificate g phys as the	edic	d				
Вох	eath certifi attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliver	у
.O.	that the dea ed by the at detached fo	Physician/Medical		Other (specify)	711	Month [Day Year
s, P	es that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
ord	v requir been si should	ted	Preumonia		1 Tes	2 □ No 3 □ Proba	bly 4 □Unknown
Vital Records,	has has	Completed			24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
/ita	cian: The	Bec	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☒ I (Check only one)	No 1 ☐ Yes 2	P□ No
of	Physician: this certific al director,	2	1 ☐ Yes 2 No Hospital: 2 ☐ ER/Outpatie			6 □Other (Specify)	
O	Attending I r death. ector: After by the funer	tlon	27. Manner of Death → Autural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	jury occurred	
	or Attendate after death Director: A in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Street City or Town, Sta	and Number or Rural i	Route Number,
	Hospitel or 4 hours afte Funerel Dir tely filled in	Ce	29a. Certifier Certifying Physician: To the best of my knowledge deat			,	
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stat nd place, and due to t	ted. he cause(s)
	To	Σ	29b. Signature and title of certifier was 12 Juneau MD	29c. License number D 00 53 8 13	29d. [Date signed (Month, Da	ay, Year)
0	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type,			- 100	
			/ Mark R. Dumais MD 75	503 Surratts Re	oad C	1 M. notril	
100	Stat Registra		JAN 1 1 2005				

CARL PHILLIP LONG-Baltimore Maryland 21215-0036

Amended Items 10e & 19b per F.D. 01/11/2005 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of Health and M Certificate of Death		/11115	01988
ı	Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Death Month	9. 140.	3. Time of Death
	/Medi Exami	ical	CARL P. LONG 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	JAN. 8	2005 4c. County of Death	4:10 A M
	LAGIIII		CARROLL HOSPITAL CENTER WESTMINSTER		CARROL	T,
	Funeral Director		5. Social Security Number 215-26-1323 6. Sex 1X M 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 12/26/	Year) 9. Birth	place (State or Foreign ntry) LAND
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ith the Marylar or 28a-f show e notified at	ctor	MD. CARROLL WESTMINSTER			1 ☐ Yes 🌺 No
	vith th	Director	10a. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
	death with the Maryland ms 23e or 28a-f show	Funeral	607 NURSEY RD. 21157 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	noity Van or No	USA	and Indian
036	or Ite	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ⋈ No Specify:	Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
21215-0036	72 hours "natural", olles Exp	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	na 10	6b. Kind of Business/In	dustry
121	within ene. then	ldmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOI		ANIIDA GOLLO	TNO
	e filed withir Il Hygiene. other then vant, It e M	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name		ANUFACTUR aiden Surname)	ING
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hyglene, item 27 is marked other then "natur other traumetic event, Ite Madical	To B	GRANT JOSEPH LONG EMMA	A GRACE	MILLER	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 1907-illinning ERT - Number STP	inster,	MD 21137 9, Zip	Code)
	f Heall fem 2 item 2 othar		20a. Method of Disposition 20b. Place of Disposition (Name of	PATHSTE	R MD 21 Oc. Location - City or To	157 wn. State
E O	Pages nent of int: If it iry or o		1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) EVERGREEN MEM. GARDENS 1			
Baltimore,	permit. Pages 1 and 2. Department of Health ar Important: If item 27 is any injury or other traconce.		21. Signutura Far all Service Licensee 22. Name and Address of Facility FLE	ETCHER 1	FUNERAL H	OME
	E # 5 0 7		254 E. MAIN ST.,			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or hear failure. List only one cause on each line. Immediate Cause (Final	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b. C. O. P. D			
	ed sit	iner	If any, leading to immediate cause. Enter Underlying Calles (Underlying			
	axecut and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	icate be executed physician and the burial-transit	ledical E	a_C·K·D			
89 ×	artifica ing ph e as th	Med	IF FEMALE:			
O. Box	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ry Day Year
ر ت	es that the de igned by the a be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
ords	w require been sig should b		Dements	1 ☐ Yes	2 □ No 3 □ Pob	ably 4 Unknown
Records,	has be	Completed	P. V.D	24a. Was an autopsy	24b. Were autop	sy findings available
E H				performe	d? death?	2 No
of Vital	Physicien: this certifice ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Dither: 4 Nursing Home			
on of	ng Pł fter († neral	\vdash	27 Manager of Death	8d. Describe how	e 6 □Other (Specify injury occurred)
Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be	8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	ha Hospit in 24 hour ha Funara pletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the caus d at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
		Σ	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, D	Day, Year)
,	AVILLA		1-00542	18 0	1-10-	2005
	NILLA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR-Raman B Kanery 349 Malcrim 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Drive	Westmins	Hen M)
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regisfra's Signature JAN 1 1 2005			2/159

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year LILLIAN CATHERINE MCCLARY JANUARY 9, /Medical 2005 05:30 A 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTERTOWN NURSING & REHABILITATION CHESTERTOWN KENT 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐XF Director 116-07-2511 94 DECEMBER2,1910 PA Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.
But: It Item 27 is marked other then "neturel", or Items 23a or 28a-1 shov ury or other treumatic event, It's Medical Examiner must be multiled at 10d. Inside City Limits Director NEW CASTLE DE NEWARK 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 STANFORD DRIVE 19711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify 3 X Widowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES TOOLE CATHERINE SPITZER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL PATRICK MCCLARY/SON 403 FAIRVIEW DR., CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Importent: It any injury or ALL SAINTS CEMETERY ' 4 ☐ Donation 5 ☐ Other (Specify) JAN.12, 2005 NEWARK, DE 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, M D21620 23a. Part1. Enter the disease, or complicated shall caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Demydration disease or condition resulting in death) clays /Medical Due to (or as a consequence of): **Examiner** cesnat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Uragan a Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 2 0 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 200 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29b. Signature and title of ပ္ 29c. License number 29d. Date signed (Month, Day, Year) MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6602 Church Hillad Chestatown Frederick Delboy, M.D. 21620 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 1 2005 Registrar

			1 - For State Registrar	State of Ma	aryland / I		artmen rtificati				•	giene Rog. No.20	05	019	911
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	/Medi	cal	MARION O. MULLIN								january	11, 2	005	8:17	ам
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			30. Name and address of person who com	pleted cause of deat	th (Item 23a) (T	ype, Pr	rint)		,						
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			For State Registrar	State	of Marylan		artmer <i>rtificat</i>					giene	005	0199	
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ย์	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	1	20a. Method of Disposition	maru / i	20b. F	Place of Dispo	sition (Na	me of			ate		ation - City or		
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Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. g r	Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	579-36-0877 1 M 2 XF 81 Yrs.	Months Days Hours Min. (AR.9,1923 PUERTO RICO
, p	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	eation	10d. Inside City Limits
shov			1XXes 2 □ No
with the Mar	MARYLAND CHARLES LA PLA	ATA 10f. Zip Code	10g. Citizen of What Country?
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of COV in the Maryland after death with the Maryland artifems 23a or 28a-f show niner must be notified at	2 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puento Rica	
S after of miner of miner	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes, Give		
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Marylan d 2 should be the and Mental to 27 is marked to traumatic every traumatic every to Ba			ute Number, City or Town, State, Zip Code)
and 2.	KENNETH H. McCOY-HUSBAND 1807	72 S. CYPRESS DR.	,COBB ISLAND,MD 20625
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene, integrated the 27 is marked other than "natural", or items 23a or 28a-1 show may injury or other traumatic event, the Martical Examiner must be notitied at any injury or other traumatic event, the Martical Examiner must be notitied at any injury or other traumatic event, the Martical Examiner must be notitied at any injury or other traumatic event, the Martical Examiner must be notitied at any injury or other traumatic event.	20a. Method of Disposition 20b. Place of Disposition		20c. Location - City or Town, State
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mit.		. Name and Address of Facility	. Og_Binital1555KU/IID
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P.O. Box 68' nat the death certificat dby the attending phyletached for use as the Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
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	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
cords vrequire been sig should b			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
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The The page			performed? death? 1
Vital Recician: The lavidicate has rector, page 2	25. Was case referred to medical	26. Place of Death (Ch	eck only one)
Division of Vital Records, for Attanding Physician: The law requires the first death. Director: After this certificate has been signed in by the funeral director, page 2 should be extification: To Be Completed by	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		5 ☐ Residence 6 ☐ Other (Specify)
On C ding P D. After t funers	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	Describe how injury occurred
Division C Division C tal or Attanding P s effer death. at Director: After I ed in by the funers Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	ocation (Street and Number or Rural Route Number.
or Al or Al or Al or Al or Al	4 Homicide determined building, etc. (Specify)		City or Town, State)
spital cours filled filled		occurred at the time, date and place, and c	due to the cause(s) and manner as stated.
Division of Vital Record To the Hospital or Attanding Physician: The law requir within 24 hours effer death. To tha Funaral Director: Affer this certificate has been s completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	(Check only 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
Mithin Sompl	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
) //#/Cice	D-22574	11/8/05
Δ.	30. Name and address of person who completed cause of death (Item 23a) (Type, I		1101
∂	ROBERT T. PACE MD 12070 OLD LI	NE CENTER SUITE	202 WALDORF MD 20602
State Registrar	31. Date filed (Month, Day, Year) 32. Begistrar's Signature		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01993 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Month Day **Physician** January Ruth Mackie Moore 18 2005 0415 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Daath Examiner Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Numbar 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) **Funeral** 1 M 2 XF Days Months Hours Min Yrs. Director 216-44-1897 Maryland Usual Rasidence of Decedent Merytand 10a Stata 10h Counts 10c. City, Town or Location 10d. Insida City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director Ceci1 Maryland E1kton the 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ŏ items 23a 21921 300 Fair Hill Drive United States Completed by Funeral 12. Was Dacadent Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ②No If Yas, Give Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Madical Exemines once. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collega (1-4or 5+) Registered Nurse Health Care 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be Harry M. Mackie Dora Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Albert V. Moore/Husband 300 Fair Hill Drive, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of camatery, crematory or other place) Jan. 21. 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Sharps Cemetery 2005 Fair Hill, Maryland 22. Nama and Addrass of Facility. Hicks Home for Funerals, P.A. 21. Signatura of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disaasa, or complications that causad the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest shock, or heart failure. List only ona causa on each line. Approximate Interval Betwean Onset and Death Physician /Medical Immadiate Cause (Final disaasa or condition rasulting in daath) on 1255100 Examiner Due to (or as a consequence of) Examine Dementio Hospital or Attanding Physician: The law requires that the death certificate be executed 24 hours efter death. Deimeis use es the burial-transit Sequantially list conditions, if any, leading to immediata ceusa. Enter Undarfying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consaquanca of): Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings availabla prior to complation of causa of death? Completed 24a. Was an eutopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was casa rafarred to medical 26. Placa of Death (Chack only one) axaminar Hospital: 1 ☐ Inpatiant Other: 4 Mursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatiant 3 ☐ DOA this After this funeral o 28a. Data of Injury (Month, Day Yaar) 27. Manner of Death 28b. Tima of 28d. Describa how injury occurred 28c. Injury at Work? 1 BNatural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant within 24 hours efter death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata) 4 - Homicida 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and manner es statad. Medicai 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. the 29b. Signature and title of certifian 29c. Licanse numbar 29d. Date signad (Month, Day, Year) DC044313 · MI) 2005 30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

Joseph K. Weidner,

IAN 2 6 2005

31. Data filed (Month, Day, Year)

32. Registrer's Signature

Jr., M.D., 101 Colonial Way, Rising Sun, Maryland 21911

December Name Private County Catherine Catherine Delores Nicholson Addition Addition Addition Addition Catherine Delores Nicholson Addition Catherine Delores Nicholson Catherine Cat			1- For State of Maryland State of Maryland		artment of H			200	5	01994
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Septiment Sept	Funeral			t birthday)	If Under 1 Year	If Under 24 Hr	8. Date of Birth	1		
Use Name of California Total			577-36-5961 1□M 2☒F 74	Yrs.	Months Days	Hours Mir	. (Month, Day Sep. 20	1930	Count	D C
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	9		Usual Residence of Decedent			<u></u>	1 2 5 2 0	1300	, abii	., 2.0.
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	nylar how	L	10a. State 10b. County 10c. City, T	Town or Lo	cation				10	d. Inside City Limits
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	e Ma	cto	MD Calvert		St. L	eonard				1 ☐ Yes 2 🔀 No
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	ith th	Oire .	10e. Street and Number		10f. Zip Code		1	0g. Citizen of W	hat Count	try?
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	23a	rai	1162 Calvert Beach Rd.		2068	5		USA	A	
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	r deg	ne		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Specify Yes or No- to Rican, etc.)			
Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	s afte , or li		If Yes, Give		_		,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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Eldred W. Nicholson, Sr., stoolse 1162 Calvert Beach Road, St. Leonard, MD 20685 Date of Date	should Me mark mark mark	ř	<u> </u>	19h Mailin	a Address (Street					Contol
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Physician Modical Examiner Ph			23a. Part1. Enter the disease, or complications that caused the death. I	Do not ente	TUSCH FUN	eral Hor	ne, P.A.,	Owings	•	
Due to (or as a consequence of): Chronic Renal Failure Due to (or as a consequence of): Chronic Renal Fai	1		snock, or heart railure. List only one cause on each line.		Λ			331,		Interval Between
Sequentially list conditions: Sequentially list conditions:			disease or condition resulting in death)							Odays.
The property of the part of th				1	F. F.	0.0				1
The at mitted events a consequence of): d		ē			x ranu	16				
FEMALE: 23. Was decedent pregnant in the past 12 months?	uted	m.	cause. Enter Underlying Cause (Disease or injury							
FEMALE: 23. Was decedent pregnant in the past 12 months?	exection and items in a fire	Exa	annuthing in death) foot	ce of):						
25. Was case referred to medical examiner? 1	e be	cal	C d.							
25. Was case referred to medical examiner? 1	g phy as th	edi								
25. Was case referred to medical examiner? 1	andin use	N/N	23h Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date	of deliven	v
25. Was case referred to medical examiner? 1	death	icia	1 Ves 2 No. 4 Pregnant at time of death					Mont	h D	Day Year
25. Was case referred to medical examiner? 1	by th	hys	9 ☐ Unknown							
25. Was case referred to medical examiner? 1	s tha			g in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contrib	oute to the	cause of death?
25. Was case referred to medical examiner? 1	quire an sig	edi	Diabetes Mellitus				1 ☐ Ye	s 2 No 3	Probal	bly 4 □Unknown
25. Was case referred to medical examiner? 1	aw re	piet	Hupertension				24a. Was ar	24b. W	ere autops	sy findings available
25. Was case referred to medical examiner? 1	The I	mo					perform	ned? de	ath?	
27. Manner of Death Same and address of person who completed bause of death (Item 23a) (Type, Print) Control of the contro	an: tiffica tor, p	0				26 Place of Dec			_1 Yes 2	.□ N0
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HOSDITAL Red SILITE 310 Prederical, MD 20678	yeici s cer		Hospital:	Outpatient	3 DOA Othe	. PT			(Speciful	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HOSDITAL Red SILITE 310 Prederical, MD 20678	g Ph erth heral		27. Manner of Death 28a. Date of Injury 28l	b. Time of						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HOSDITAL Red SILITE 310 Prederical, MD 20678	ath. T: Aft	atio	Jan Valdida	III)uty						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HOSDITAL Red SILITE 310 Prederical, MD 20678	r Atte	tific	determined 286. Place of Injury - At nome	, farm, stre	et, factory, office				or Rural I	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HOSDITAL Red SILITE 310 Prederical, MD 20678	safte	Cert	building, etc. (Specify)				City of Town,	, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 HOSDITAL Red SILITE 310 Prederical, MD 20678	lospi Lhour uner		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	dge, death	occurred at the time	e, date and place	, and due to the ca	use(s) and man	ner as stat	ed.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hospital Rd Sinte 310 Prederical, MD 20678	the H nin 24 the F	Medi	and manner stated.	41140111111			ared at the time, da	ne and place, an	d due to ti	ne cause(s)
10 110 Hospital Rd Stute 310 PFrederick MD 20678	To To	-	23D. Signature and title of certifier		29c. License	number	29	d. Date signed (Month, Da	ay, Year)
10 110 Hospital Rd Stute 310 PFrederick MD 20678			you white pur		LX00	52190	2	January	44,	2005
	/I		30. Name and address of person who completed cause of death (Item 23)	a) (Type, F	Print)		10 -	(J	
Registrar IAN 0.6 2005 Mars M. A. M.			31 Date filed (Month, Day, Year) 32 Registrate Signature	10	Freau	uce	20	16 18.		
registral	Sta Registr		JAN 0 6 2005 ▶ Kenner	K.	Spart's	/				

			1 For State	State of Marylar				d Mental Hy	/giene	
			Registrar 1. Decedent's Name (First, Middle, Last,	1	Ce	rtificate of	Death	10.5	Reg. No.	01995
	Physic	ian	01.1					2. Date of D Month	eath Day Yea	3. Time of Death
	/Medi		Gladys W. Neh	louse		4b. City, Town, o	al continue of D		ry 10, 2005	
	Examir	ier	Crumland Farms H			Freder		eatri	4c. County of De	
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 h		Frederi	
	Director		218-18-3612	∃M 2[X]F 88	Yrs.	Months Days	Hours M	lin. (Month, D		irthplace (State or Foreign Country) ryland
	pu		Usual Residence of Decedent 10a. State 10b. County	100 0	y, Town or Lo				7, 17,10, 110	
	Aanyle I sho	ō								10d. Inside City Limits 1X Yes 2 □ No
	the 1	Director	Maryland Frederic	k Fr	ederic	k 10f. Zip Code			100 Citizen of Miles	
	3a or	0	1342 Hillcrest Dr	ivo		21703			10g. Citizen of What (
	ms 2	Funeral		12. Was Decedent Ever in U	.S. 13. \			(Specify Yes or No erto Rican, etc.)	U.S.A	
9	or He	/Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				erto Rican, etc.)		ite, etc.
8	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or items 23a or 28a-f show int, the Mcdreal Examiner must be notified at	d by	3 Vidowed 4 Divorced	Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify: W	hite
7	"net	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of v	vorking	16b. Kind of Busines	
7	withii lene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	th Techni			Montgomer Governmen	,
<u> </u>	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)		11001	on reemin		lame (First, Middle	, Maiden Sumame)	L
<u>a</u>	Aental Aental rked o	To B	Ira Dorsey	Watkins			Flore		esworth	
Maryland 21215-0036	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street a	and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
	and sealth		Patricia C. Morris			Hillcres	st Drive	e, Freder	ick, Maryl	and 21703
more,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene. Int: If item 27 is marked other then "netural", or items 23a or 28a-f show int: If item 27 is marked other then "netural", or items 25a or 28a-f show ity or other treumatic event, the Michael Examples must be notified at		20a. Method of Disposition 1 □XPorial 2 □ Cremation 3 □R	emoval from State	lace of Dispo: emetery, cren	sition (Name of natory or other place	9)	Date	20c. Location - City of	r Town, State
=	t. Pa tmen tent:		` 4 ☐ Donation ☐ Other (Specify)	Мо				17, 200	5 Damascus	, Maryland
Ba	permit. Page Department Importent: Il eny injury o		21. Sign ture of Fune I Service License	2 (11)	/ [01	. Name and Addres in L. Mol	.eswortl	n P.A., F	uneral Home	e
			23a. Part1. Enter the disease, or compli	cations that caused the death	26	401 Ridge	Road	Damagen	e Marylan	20872 Approximate
	Physician		Immediate Cause (Final	e cause on each line.	. 1	(Interval Between Onset and Death
r	/Medical		disease or condition resulting in death)	Due to (or as a consequ	resce of):	mers	Her	vestra		Gens.
	Examiner		Compostially list conditions h	,	,,,,					0
	g ## Q	iner	Sequentially list conditions, if any, leading to immediate oauce. End ultimorphying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	. Due to (or as a consequ	ioneo efti					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	cal E		Due to (or as a consequ	rence or):					
687	ficate g phys is the	ᇹ	d							
Box	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	liven
4	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
J O	at the de by the a stached	Physician/Me	9 ☐ Unknown	9L Unknown		_				
	law requires that the as been signed by th 2 should be detache	ρχ	Part II. Other significant conditions con	tributing to death but not resu	ılting in the un	derlying cause give	n in Part I.		obacco use contribute t	
0	w requires to been signer should be	ompleted						101	Yes 2.22HNo 3.∏.P	robably 4 Unknown
ec C	has b	nple						24a. Was autop	osy prior to	topsy findings available completion of cause of
Vital Records,	The ate	O							rmed? death?	2 □ No
	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:		0.11	/	eath (Check only o	Silling and the second	
	ding Phys h. After this funeral dir	-	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury Work	4 Nursing		dence 6 Other (Spe	cify)
0	Attending or death. ector: After by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? es 2□No			
Division	r Atte	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or Ri	ural Route Number,
2	oitel c urs af orel D	O							·	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Exemin	icien: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the time estigation, in my opi	e, date and place nion, death occ	ce, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of tertifier	direction states.		29c. License	number		29d. Date signed (Mont	h. Day. Year)
) Bell			D2	6499			
	6	-	30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, P		U + J J		January 11	, 2005
			Ronald E. Mille			Drive, M	ount Ai	ry, Mary	land 21771	
	Sta	te ar	31. Date filed (Month, Day, Year) JAN 1 2 20	32. Registrar's Signati	ure.	male 1				

			For State Registrar	State of Maryland /		artment of Heartificate of De			201	15	01	997
10	•	W,	Decedent's Name (First, Middle, Last)			tineate of De	alli	2. Date of Death	g. No.		3. Time o	of Death
	Physici /Medi		GRACE	RICHARDSON			J	anuary 2	Day	Year	5:49	РМ
	Examir	ıęr	4a. Facility Name (If not institution, give s SOUTHERN MARYLAND			4b. City, Town, or Loc CLINTON	cation of Death		4c. County of PRINCE		RGE'S	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthpla	ace (State	or Foreign
Ų,	Director		577-22-5943 Usual Residence of Decedent	M 2⊠F 90	Yrs.			Juneth, Bay,	1914	Jashi	ingto	n DC
	nyland show	_	10a, State 10b. County	10c, City, To	wn or Lo	cation				10	Od. Inside C	City Limits
	he Ma 28a-f s	ecto	MD Prince Ge	orge's Clint	ton	71111111						s 2 No
	h with 13a or 3	al Dir	10e. Street and Number 9211 Stewart Lane			10f. Zip Code 20735			g.Citizen of WI J nited		-	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic avant. The Macfield Examine Lust by Incition at ADDE.	by Funeral Director	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	l I	Vas Decedent of Hispa f Yes, specify Cuban, N I Yes 28 No S	nic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		- America , White, e Black	etc.	
5-0	"natur	eted	15. Decedent's Educ (Specify only highest grade	cation 16a	(Give	lent's Usual Occupation kind of work done durin	n ng most of workin	ng 1	6b. Kind of Bus	iness/Indi	ustry	
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	al Hyg d othal	BeC	17. Father's Name (First, Middle, Last)					(First, Middle, Mi)		
Maryland	d Menld I	P P	Unknown 19a. Informant's Name/Relationship (Ty)	no Brint)	b. \$4-00-		Unkn					
Ma,	alth an 127 is r		Tonya C. Trufant /			g Address <i>(Street and I</i> Stewart Lai				tate, Zip (Code)	
Baltimore,	Pages 1 and of He not of He not: If itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemete	эгу, сгеп	sition (Name of natory or other place) itan Cremat	. 1	/2005 Al	oc. Location - C			
Balti	permit. Departm Importa any inju		21 Signature of Funeral Service License	Dans	100	Name and Address of Penn A	Facility Ale	xander S	. Pope	Fune		Home
160	Pnysician		23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	cations that caused the death. Do e cause on each line		er the mode of dying, su	uch as cardiac or			í	Approximat Interval Bet Onset and	tween
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	of):	ruly in	anction since			-		
	Examiner	ē	Sequentially list conditions, if any, leading to immediate	the to (or as a consequence		Antry Du	sine					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(80)						-		
8760,	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence	of):							
9		Jedical	IF FEMALE:									
.O. Box	at the death certific by the attending p tached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date Month	,	,	Year
α.	s that t ned by e detac	by Ph	Part II. Other significant conditions con	tributing to death but not resulting i	in the un	derlying cause given in	Part I.	23e. Did toba	cco use contrib	ute to the	cause of c	death?
ords	w requires that been signed b should be deta							1 ☐ Yes	2 □ No 3	Probab	bly 4 □l	Jnknown
I Records,	The la ate has page 2	Completed						24a. Was an autopsy performe	d2 prid	ere autops or to comp ath?] Yes 2	sy findings pletion of c	available ause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		Oak		(Check only one)				
	Phya rr this o	: To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a, Date of Injury 28b,	utpatient Time of			e 5 🗆 Residend 3d. Describe how				
ion	Attanding P death. ctor: After ty the funera	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes			injury occurred			
Division of	fiter pira n b	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specily)	arm, stre	et, factory, office	28	Bf. Location (Stree City or Town, S		or Rural F	Route Num	ber,
_	To the Hospital within 24 hours a To the Funaral C completely filled in	O	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	e, death	occurred at the time, da	ate and place, an	nd due to the caus	se(s) and mann	er as stat	ted bet	it
	To tha Hos within 24 h To tha Fun completely	ledical	one)	er: On the basis of examination ar and manner stated,	nd/or inve	estigation, in my opinior	n, death occurred	at the time, date	and place, and	due to th	ne cause(s)
) .	To To To Con	Σ	29b. Signature and title of certified	m m)		29c. License nun			Date signed (_	_	
			30. Name and address/of person who cor		(Type, P	D0055			_	2005	F	
			Richard Pahnerma	1328 Southern Aven	ne	SE Sunte.	310 Wash	nyhun D	C 200	32		
ë.	Sta Registr	_	31. Date filed (Month, Day; Year) JAN 1 1 2005	npleted cause of death (Item 23a) 328 Sorthum Aven 2. Registrar's Signature.	for	E)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 4, 2005 Year **Physician** William Edward Rourke, Jr. 1920 P. M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince Georges Hospital Prince Georges Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 17, 1948 Connecticut 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1**∑**M 2□F Months Days Hours Min Yrs. Director 041-42-1453 56 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 27 is marked other then "netural", or items 23e or 28e-f show treumatic event, the Modical Exercited required as 1 XYes 2 No Director Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 USA 4930 Colonel Contee Place Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Anned Folces: 1 Yes 2 No If Yes, Give Year or Dates:Viet Nam 1 Never Married 2√2 Marned 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail sales Automobile d 2 should be filed with and Mental Hygier 7 is marked other th 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Cuddahy William Edward Rourke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 4930 Colonel Contee Pl., Upper Marlboro, Md. 20772 Julia B. Weatherly - Wife 20b. Place of Disposition (Name of cometery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1-07-05 Crownsville, Md. Maryland Veterans Cemetery 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intra cerebral bleed disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Multiple rib fractures use as the burial-tran the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Cther (specify) 4 Pregnant at time of death 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 XUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 🏋 No 2 Accident 3 Suicide 01/02/2005 0005 A M Fell down 25 steps 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Upper Mariboro, MD 4 Homicide Home - 4930 Colonel Contee Pl. 4930 Colonel Contee PL. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending after death Director: 24 hours a within 2 2

liled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year) JAN 1 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Ty

A. DAES

29b. Signature and title of certifier

SAID



MO

29c. License number

09

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of Ivia	,		ertificat				Reg. No.	005	01000
	Dhysisi	20	1. Decedent's Name (First, Middle, Last							2. Date of D	eath	Voor	3. Time of Death
	Physici /Medio		Bessye Leola Ro	eder						Januar	y 7, 20	005 ^{ear}	9:15PM
)	Examir	ner	4a. Facility Name (If not institution, give						4b. City, Town, or	Location of Dea	th 4c. Cou	nty of Death	
			Manor Care Nursin 5. Social Security Number 6. Se				If Lindo	r 1 Year	Wheaton			tgomery	
	Funeral Director			Эм 2ХСХF /	e (In yrs. la		Months	Days		Jan. 2	ay, Year) 5 , 1902	9. Birthplac Country 2 Maryla	ce (State or Foreign and
	yland ***		10a. State 10b. County		10c. City	, Town or	Location					10d	I. Inside City Limits
	Mar st	ctor	Maryland Montgome	ry	Whea	ton							1 ☐ Yes 2 💆 No
	₹ 28	Olre	10e. Street and Number				10f. Zip	Code			10g. Citizen	of What Country	n
	ath w	ral	11901 Georgia Ave					902	***		USA		
020	parmit. Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is merked other than "natural; or items 23a or 28a-f show any Injury or other traumatic evant, Ite Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		5. 13	I. Was Dece If Yes, spe 1 ☐ Yes		Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Note 1		Race - American Black, White, etc cify: White).
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Dec	edent's Usu	al Occup	pation during most of wo d)	rkina	16b. Kind of	Business/Indus	stry
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75	lled v Hygier her ti nt, in	ပိ	12 17. Father's Name (First, Middle, Last)			Home	emaker		10 Mathada Na	me (First, Middle	Own Ho		
au	d be fantal l	B B	John Henry Brown							E. Keen		iame)	
کے	shoul nd Me mark imatí	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Ma	ilina Address	(Street	and Number or Ri			vn State Zin Ci	nde)
ž	alth e 27 is rrau		John A. Roeder Jr	. / son					Woods Wa				
altimore, Maryland 21215-0020	Peges 1 a ent of He at: if item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				oosition (Nare ematory or d			Jan. 10		n - City or Town	
a ===	mit. Partmy sartmy sortar		21. Signature of Funeral Service Licens						ss of Facility Cremati	2005	Odento	on, Mary	land
m	E E E) Y	Bevalls L.H.	estatte	Mal								, MD 21029
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin								A	pproximate terval Between nset and Death
	/Medical Examiner	<u>.</u>	Immediate Cause (Final disease or condition resulting in death)	. Chronic			ic Le	uken	nia				
	uted f insit	Examiner	C 1),									
oʻ	rrificate ba axecuted ing physician and as the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Jua to (or i	as a cons	squerice of).						
09/89	ate be hysici the bu	Medicai	Cause (Disease or injury that initiated events resulting in death) Last)	Due to (or a	as a conse	quence of):						
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9	attand for us	ian			700				-3-16				
P.0.	the da	ysic	Part II. Other significant conditions con	tributing to death bu	t not result	ing in the	underlying c	ause giv	en in Part I.	23b. Dld	tobacco use o	contribute to th	e cause of death?
J	as thet the daath ca igned by tha attandi be detached for uso	by Physician/	Alzheimer's Diseas	se						10	Yes 2□ No	3 Probab	ly 4 ⊈Unknown
of Vital Records,	raquir Deen s Should	Completed b								24a. Was	an autopsy ormed?	availa	autopsy findings ble prior to etion of cause th?
ř	nysician: The law nis certificate has I I diractor, page 2 s	E								10	Yes 2⊠No		es 2□No
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1	Attending Physician: r death. actor: After this certific by the funeral diractor.	ို	1 ☐ Yes 2 ☐XNo	ospital: 1 Inpatier			ent 3D DO		443 Nursing H	lome 5 ☐ Resi	dence 6 □0	ther (Specify)	
בַ וַ	ing P	<u>ë</u>	27. Manner of Death 1 □XNatural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 2	28b. Time Injury		8c. Injur Wor		28d. Describe	how injury occ	urred	
<u>s</u>	ttending F death. stor: After y the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	nr. At hom	a farm e	M treet factors		Yes 2 □ No	28f Location (Stroot and Mus	mber or Rural Ro	outo Alumbar
	5 # F =	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	ie, iaiiii, s	ileei, lactory	, onice		City or To		nder or Hurai Hi	oute Number,
	Hospita 14 hours Funeral taly fille	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	er: On the basis of a	examinatio	edge, dea n and/or i	th occurred anvestigation,	at the tim	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and r date and place	manner as state	d. e cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stat	ed.	7-			e number			ned (Month, Day	
	F 3 F ŏ	56	· Clan &	lea	al	1	1						
5	ad		30. Name and address of person who co	mpleted cause of de	ath (Item 2	3a) (Tvpe		5226	0.1	,	January	7, 200	15
3)	W.,		Alan R. Segal M.D.					r Sp	ring, MD	20906			
	Stat	te ar	31. Date filed (Month, Day, Year) JAN 1 2 20	32. Pogistra	r's Signatu	re		_					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. U 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 17, 2005 Betty Mae Robrecht **Physician** 3:55 P. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** California St. Mary's 44755 Woodlake Court If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🕱 F 80 June 15,1924 Maryland 218-18-5689 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Execution or must be notified at 1 Yes 2 No Director Maryland St. Mary's Tall Timbers 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 44760 Tall Timbers Road 20690 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Supervisory Supply Clerk US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Clarence T. Melvin Alice Eagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 s Department of Health an Importent: If item 27 is any injury or other trau 44755 Woodlake Court #754, California, Maryland 20619 Carol Ridgell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Doption 5 ☐ Other (Specify) Metropolitan Crematory Jan 19,2005 Arlington, Virginia e of Funeral Service Vicensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, Leonardtown, Maryland 20650 Nichael Hardine 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only the cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 3 months **Physician** CENTERO VISCULAR disease or condition resulting in death) ACCIDENT /Medical Due to (or as a consequence of) **Examiner** ATHEROS CLEROSIS SKUWAAL YKARS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atter Year Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate has 2 No 1 Yes 200 No 1 Yes Physiclen: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral dir 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending 1 Natural 5 Pending s after death, il Director: Af in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the state 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 1)0014/68 1-18-05 Bauer , mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28170 OLD VILLAGE Rd., Mechanics ville, Md. 20659 M.D. Robert J. Bauer, 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar 8